Colposcopy Clinic Referral Form

Booking **TELEPHONE**: 250-370-8884 **FAX**: 250-519-1551
RJH D&T Building
1952 Bay Street
Victoria, BC V8R 1J8

Patient Information:	**Medical Record Number:**
Name: _____	
DOB: _____ **PHN:** _____	
Preferred Name: _____	
Address: _____	
Telephone: _____	

Referring Physician/Billing Number:	**Physician Phone/Fax Number:**	**Family Physician (if different):**

Financial Responsibility

☐ BC Resident – MSP ☐ Other Province _____ ☐ uninsured Services
☐ Non-Resident Canada ☐ Self ☐ Armed Forces

Cytology Result	**Other Reason for Referral**	**Procedure Requested**	**Preferred Physician**
○ Unsatisfactory Squamous ○ ASC-US ○ LSIL (mild) ○ ASC-H ○ HSIL (Mod) ○ HSIL (Marked) ○ Carcinoma in situ ○ Malignant Glandular ○ AGC NOS ○ AGC Neoplastic ○ AIS ○ Malignant *** ALL REFERALS MUST INCLUDE CYTOLOGY RESULT**	○ Clinical abnormality of the Cervix ○ DES ○ Other _____ _____ Cytology result out of Province? **YES NO**	○ Colposcopy ○ Repeat colposcopy ○ LEEP ○ Follow-up ○ Vulvoscopy	○ First Available ○ Dr Cohen ○ Dr Hancock ○ Dr Hunt ○ Dr Mazgani ○ Dr Quinlan

Pregnant YES NO Weeks _____	**Allergies/Sensitivities** _____ _____ _____	**Special Needs** _____ _____ _____ _____

Appointment Date/Time	**Patient Notified** YES NO