



HCN: _____
 Province/Territory: _____ Expiry: YYYY / MON / DD
 Name: _____
 First Middle Surname
 Date of Birth: YYYY / MON / DD Sex: M F UN
 Mailing Address: _____
 City: _____ Prov/Terr: _____ Postal Code: _____
 Telephone: (Indicate Preferred) Home (____) - ____ - ____
 Cell (____) - ____ - ____ Work (____) - ____ - ____

**Colposcopy Referral Form -
 Abnormal PAP Cytology**

Ordering Provider's Name _____ Clinic Name: _____ Mailing Address _____ City: _____ Prov/Terr: _____ Postal Code: _____ Phone: (____) - ____ - ____ Fax: (____) - ____ - ____ Ordering Provider's Meditech Mnemonic: _____ Signature: _____ Date: <u>YYYY</u> / <u>MON</u> / <u>DD</u>	Clinic Stamp: (include fax, provider and mnemonics) EMR Clinic Mnemonic: _____ COPY TO PROVIDER
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Instructions: Complete form and fax to Gynecologist - retain a copy for your records.

Date of Referral: :YYYY / MON / DD **Gynecologist:** _____

Clinical Information

Reason for Consult:

<input type="checkbox"/> LSIL (Low Grade Squamous Intraepithelial Lesion)	<input type="checkbox"/> HSIL (High Grade Squamous Intraepithelial Lesion)
<input type="checkbox"/> ASC-US (Atypical Squamous Cells of Undetermined Significance).	<input type="checkbox"/> ASC-H (Atypical Squamous Cells cannot excude HSIL)
<input type="checkbox"/> AGC (Atypical Glandular Cells)	<input type="checkbox"/> Abnormal Appearance of Cervix
<input type="checkbox"/> Other	

Date of Abnormal Pap Test: :YYYY / MON / DD

<input type="checkbox"/> Not Pregnant	<input type="checkbox"/> Pregnant	<input type="checkbox"/> Para	<input type="checkbox"/> Gravida	<input type="checkbox"/> Abortions
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Significant Medical/Surgical History:

Allergies:

List all relevant medications:

To be completed by Specialist

Date Requisition Received: YYYY / MON / DD **Ordering Physician Notified:** Phone Message Mail

Schedule appointment in: 2 weeks 4 weeks 6 weeks 12 weeks Other(Specify) _____

**Gynecologist office to return to the referring physician and fax to the Registry @ 752-6710.
 Please keep a copy for your records.**