Cancer Care Program

Provincial Cervical Screening Initiatives Program
Abnormal Pap Cytology – COLPOSCOPY REFERRAL FORM

Instructions: Complete form and fax to Gynecologist – retain a copy for your records

Patient Information	Physician Information (please use stamp)
Name: ______________________	
MCP#: ______________________	
Date of Birth: DD/MONTH/YYYY Age: _____	
Address: ______________________	Physician Signature: ______________________
______________________	Date: DD/MONTH/YYYY
	Copy report to (please print): ______________________
Telephone: ______________________	

Date of Referral: DD/MONTH/YYYY Gynecologist: ______________________

Clinical Information

Reason for Consult:
- ☐ LSIL ☐ AGC
- ☐ HSIL ☐ ASC-H
- ☐ ASC-US
- ☐ Abnormal Appearance of Cervix
- ☐ Other: ______________________

Key:

ASCUS – Atypical Squamous Cells of Undetermined Significance
LSIL – Low Grade Squamous Intraepithelial Lesion
ASC-H – Atypical Squamous Cells cannot exclude HSIL
HSIL – High Grade Squamous Intraepithelial Lesion
AGC – Atypical Glandular Cells

Date of Abnormal Pap Test : DD/MONTH/YYYY

☐ Pregnant ☐ Not Pregnant P ara G ravida A bortions

Significant Medical / Surgical History / Allergies:

List All Relevant Medications:

To be completed by Specialist

Date Requisition Received: DD/MONTH/YYYY Ordering Physician Notified: ☐ Phone ☐ Message ☐ Mail

Appointment date: ______________________ on DD/MONTH/YYYY at ______________________

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

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