

Note: Samples must be properly labeled with the patient's surname and date of birth or sample will be rejected.

Yellow highlighted fields must be completed. Only 1 vial (or 1 swab) is required except for patients with a double cervix.

Patient PHN	Patient DOB (dd/mmm/yyyy)	Follow-up Practitioner/Clinic (MSP#, Name, Address)	
Patient Last Name	Patient First Name & Initials		
Gender (for administrative purposes) FEMALE MALE U (Unknown) X (Non-binary)		Sample Provider (MSP# & Name)	locum RN ND
Sample Date (dd/mmm/yyyy)	LMP Date (dd/mmm/yyyy)	Copy to MSP# & Name	Copy to MSP# & Name

COLLECTION METHOD / SAMPLE SITE:	
LBC vial: Cervix/Endocervix	Vaginal swab: self-collect
LBC vial: Vaginal Vault/Wall <i>(collected with spatula/brush)</i>	Vaginal swab: provider-collect
REASON FOR TEST:	
Primary/Asymptomatic screening Follow-up after self-collect HPV Other High Risk Positive (cytology) Follow-up at 12-months after HPV Other High Risk Positive (HPV) Follow-up after colposcopy discharge (Co-Test) Clinical abnormality - Abnormal bleeding (unexplained)* Clinical abnormality - Suspicious lesion* <i>*A screening test is not appropriate for individuals with signs/symptoms suggestive of cervical cancer. Further investigation is required. A Co-Test (HPV and cytology) will be performed but test results are <u>not required for referral</u>.</i>	

REASON FOR TEST - COLPOSCOPY USE ONLY	
HPV	Follow-up of HPV Other High Risk Positive Follow-up of HPV 16/18 Positive Other (please specify): _____
Co-Test	Follow-up of CIN2+ or AIS DES exposure in utero Investigation of clinical abnormality (please specify): _____
Cytology only	Follow-up of self-collect HPV Other High Risk Positive Other (please specify): _____

CLINICAL INFORMATION:	
IUD	
DES exposure in utero	<i>**Please refer to the BC Cancer Cervix Screening Program Overview document</i>
Pelvic radiation	http://www.bccancer.bc.ca/screening/health-professionals/cervix/resources
Immunocompromised**	
CLINICAL COMMENTS:	

OUT OF PROVINCE cervical abnormality (histologically proven)	
Date: _____	Location: _____
CIN2, CIN3	AIS (Adenocarcinoma in situ)
Invasive cervical carcinoma	
Total Hysterectomy (cervix removed)	
Date: _____	Pathology number. : _____
Unknown reason	Invasive cervical carcinoma
No cervical abnormality	Endometrial carcinoma
CIN2, CIN3	Malignant, other:
AIS (Adenocarcinoma in situ)	<i>Please specify:</i> _____

DELIVER SAMPLES TO: Cervical Cancer Screening Laboratory 655 West 12 th Avenue Vancouver, BC V5Z 4R4	CONTACT: (T): 1-877-747-2522 (1-877-PHSA-LAB) (F): 604-707-2809 <u>Supplies and electronic requisition:</u> http://www.bccancer.bc.ca/health-professionals/clinical-resources/laboratory-services/cervical-cancer-screening	LAB USE ONLY:
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