DO NOT PLACE LABEL ABOVE LINE

BC CANCER CERVIX SCREENING
Provincial Health Services Authority

REFERRAL UPDATE FORM

AFFIX CLIENT LABEL HERE

PRESS FIRMLY TO ENSURE LEGIBILITY
FAX TO CERVIX SCREENING PROGRAM: 1 (604) 297-9327

REFERRAL DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F|M|X)

FACILITY NAME | AMENDED DATE (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD)

REFERRING PROVIDER (MSC) | REFERRING PROVIDER LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

SELECT ONLY ONE OPTION BELOW

TRANSFER REQUEST *Complete only if referral requires a transfer to another clinic.*

Transfer Request To: _____
(Name of Colposcopy Clinic or City)

Reason: ☐ Medical Reason ☐ Patient Preference ☐ Patient Address Related

☐ Other (Please specify): _____

PATIENT NOT PROCEEDING FOR FOLLOW UP *Complete only if patient is not proceeding for further follow up at your clinic.*

Please ensure the patient's primary provider has been notified if the patient is not going to proceed.

☐ Patient had a total hysterectomy, no further follow up required
☐ Patient declined follow up
☐ Patient was not able to be contacted
☐ Patient moved out of province
☐ Patient is medically unfit for follow up
☐ Patient went to a different clinic for follow up, provide clinic if known: _____
☐ Patient is deceased
☐ Other: _____

_____ Completed By

_____ Signature