40210

BC CANCER CERVIX SCREENING
Provincial Health Services Authority

TREATMENT FORM

FAX TOP COPY TO CERVIX SCREENING PROGRAM: 1 (604) 297-9327

AFFIX CLIENT LABEL HERE

PHN | PATIENT NAME LAST | PATIENT NAME FIRST | GENDER (F/M/X)

DATE OF BIRTH (YYYYMMDD) | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST | AMENDED DATE (YYYYMMDD)

EXAM DATE (YYYYMMDD) | FACILITY NAME | REFERRING PROVIDER (MSC) | REFERRING PROVIDER LAST, FIRST

1. INDICATION

☐ Treatment of ☐ Diagnosis

☐ CIN 2/3 ☐ AIS ☐ CIN 1 on bx ☐ Bx not possible

☐ VAIN 2/3 ☐ VIN 2/3 ☐ Cyto/histo discrepancy 2+ levels

☐ Malignant

☐ Other _____

2. PATIENT DOCUMENTATION

Patient identity confirmed ☐ Yes ☐ No

Verbal or written consent ☐ Yes ☐ No

Allergies documented ☐ Yes ☐ No

Pregnancy test ☐ Not done ☐ Pos ☐ Neg

Comments

3. PROCEDURE

Anatomical Site ☐ Cervix ☐ Vagina ☐ Vulva

Size of Lesion ☐ Not visible ☐ <1cm ☐ 1-2cm ☐ >2cm

Anesthetic ☐ Local ☐ Sedation ☐ General

Other Medications _____

4. LOCATION OF PROCEDURE

☐ Colposcopy Clinic

☐ Operating Room

☐ Patient related (anxiety or anatomy)

☐ No access to clinic setting

5. PROCEDURE TYPE

☐ **LEEP** Loop Size _____ Voltage _____ Blend _____ Cut _____

# of Fragments ☐ 1 ☐ 2 ☐ >2 Top hat excision ☐ Yes ☐ No

☐ **Laser** ☐ Safety check completed Power _____ Mode _____

☐ **Cone**

☐ **Cryotherapy** Freeze technique _____

☐ **Wide Local Excision** Excision size /description _____

6. OTHER PROCEDURES

☐ ECC ☐ Cervical Bx ☐ Vaginal Bx ☐ Vulvar Bx ☐ Endometrial Bx

☐ Other _____

7. UNPLANNED EVENTS ☐ None

☐ Pain ☐ Vasovagal ☐ Bleeding ☐ Flush ☐ Other _____

COMMENTS _____

8. PATHOLOGY RESULTS

☐ Negative for Dysplasia

☐ HPV/Condyloma ☐ Benign Atypia

☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ AIS

☐ Microinvasive SCC ☐ Malignant SCC

☐ Adenocarcinoma

☐ VAIN 1 ☐ VAIN 2/3 ☐ VIN1 ☐ VIN 2/3

☐ Other _____

Margins

☐ Negative ☐ Positive ☐ Indeterminate

Comments

9. RECOMMENDATIONS

Date (YYYYMMDD) _____

HPV Vaccine Recommended ☐ Yes **HPV Vaccine Rx Provided** ☐ Yes

Return to Colposcopy Clinic

☐ Repeat Colposcopy in ____ months (Booked: ☐ Yes ☐ No)

☐ Treatment within ____ months (Booked: ☐ Yes ☐ No)

☐ Cervix ☐ Vagina ☐ Vulva

☐ LEEP ☐ Laser ☐ Other _____

☐ Patient Referred to BC Cancer

☐ Gynecological Consult (Colposcopist Arranging)

☐ Hysterectomy Discussion

☐ Other _____

☐ No Further Screening or Colposcopy Required _____

Name _____ MSC _____ Signature _____

Attention Referring Physician

☐ **Inform Patient of Result** ☐ **Patient Aware of Result**

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IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604)708-2114