DO NOT PLACE LABEL ABOVE LINE

BC CANCER CERVIX SCREENING Provincial Health Services Authority

TREATMENT FORM

AFFIX CLIENT LABEL HERE

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

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

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

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

REFERRING PROVIDER (MSC) | REFERRING PROVIDER LAST, FIRST
(If different from Primary Provider above)

1. INDICATION

- ☐ Treatment of:
  - ☐ CIN 2/3
  - ☐ AIS
  - ☐ VAIN 2/3
  - ☐ Malignant
- ☐ Diagnosis
  - ☐ CIN 1 on bx
  - ☐ Bx not possible
  - ☐ Cyto/histo discrepancy 2+ levels
- ☐ Other: _____

2. PATIENT DOCUMENTATION

Patient identity confirmed
☐ Yes ☐ No

Verbal or written consent
☐ Yes ☐ No

Allergies Documented
☐ Yes ☐ No

Pregnancy Test
☐ Pos ☐ Neg ☐ Not done

COMMENTS

3. LOCATION OF PROCEDURE

- ☐ Colposcopy Clinic
- ☐ Operating Room
  - ☐ Patient related (anxiety or anatomy)
  - ☐ No access to clinic setting

4. PROCEDURE

Anatomical Site
☐ Cervix ☐ Vagina

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

Anesthetic
☐ Local ☐ Sedation ☐ General

Other Medications
_____

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
☐ Endometrial Bx ☐ Vaginal 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 ☐ HSIL NOS ☐ AIS
☐ Microinvasive SCC ☐ Malignant SCC
☐ Adenocarcinoma ☐ VAIN 1 ☐ VAIN 2/3
☐ Other: _____

Margin
☐ Negative ☐ Positive ☐ Indeterminate

Comments

9. RECOMMENDATIONS (Complete only 9a or 9b) Date (YYYYMMDD)

9a. Return to Colposcopy Clinic

Colposcopy in: Booked: ☐ Yes ☐ No
☐ 6 Months ☐ 12 Months ☐ _____ Months

Treatment within: Booked: ☐ Yes ☐ No
☐ 2 Months ☐ _____ Months
Site: ☐ Cervix ☐ Vagina
Type: ☐ LEEP ☐ Laser ☐ Other: _____

9b. Other Recommendation

☐ Patient Referred to BC Cancer

☐ Gynecological Consult (Colposcopist Arranging)
☐ Hysterectomy Discussion
☐ Other: _____

HPV Vaccine
☐ HPV Vaccine Recommended
☐ HPV Vaccine Rx Provided

Attention Provider
☐ Inform Patient of Result
☐ Patient Aware of Result

Colposcopist Signature

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