DO NOT PLACE LABEL ABOVE LINE

BC CANCER CERVIX SCREENING
Provincial Health Services Authority

COLPOSCOPY 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

1. HISTORY

Parity_____ LMP_____

Pregnant ☐ Yes ☐ No

Postmenopausal ☐ Yes ☐ No

HRT ☐ Yes ☐ No

HPV Vaccine 2+ Doses ☐ Yes ☐ No

Year: _____ Type: _____

Previous Treatment (eg LEEP) YYMM

_____ _____

_____ _____

_____ _____

Current Smoker ☐ Yes ☐ No

Immunocompromised ☐ Yes ☐ No

Other History: _____

REFERRING PROVIDER (MSC) | REFERRING PROVIDER LAST, FIRST

(If different from Primary Provider above)

2. REASON FOR COLPOSCOPY (Select one option below)

☐ Abnormal Screen Date (YYYYMMDD) _____

☐ Unsat ☐ ASC-US ☐ LSIL ☐ HPV Positive Type: _____

☐ ASC-H ☐ HSIL Mod ☐ HSIL Severe ☐ Malignant Sq

☐ AGC NOS ☐ AGC-FN ☐ AIS ☐ Malignant GI

☐ Clinical Abnormality: _____

☐ Repeat Colposcopy for: _____

☐ Treatment Follow Up Year of Treatment: _____ Visit #: _____

☐ CIN 2/3 ☐ AIS ☐ Cancer ☐ VAIN

☐ HPV Negative ☐ HPV Positive Type: _____

☐ Other: _____

3. COLPOSCOPIC EXAMINATION

Site Examed

☐ Cervix ☐ Vagina

Adequacy (Cervix)

☐ Adequate ☐ Inadequate

Transformation Zone

☐ Type 1 ☐ Type 2 ☐ Type 3

Biopsy (Cervix)

☐ Done ☐ Not Done

ECC

☐ Done ☐ Not Done

Other Procedure

☐ Endometrial Biopsy ☐ Pap Test

☐ Vaginal Biopsy ☐ HPV Test

4. IMPRESSION

☐ Negative for Dysplasia

☐ HPV/Condyloma ☐ Benign Atypia

☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ AIS

☐ Microinvasive SCC ☐ Malignant SCC

☐ Adenocarcinoma ☐ VAIN 1 ☐ VAIN 2/3

Diagram for lesion

BIOPSY SITE

Comments

5. RESULTS

☐ Negative for Dysplasia ☐ Insufficient Samples

☐ HPV/Condyloma ☐ Benign Atypia

☐ CIN 1 ☐ CIN 2 ☐ CIN 3 ☐ HSIL NOS ☐ AIS

☐ Microinvasive SCC ☐ Malignant SCC

☐ Adenocarcinoma ☐ VAIN 1 ☐ VAIN 2/3

☐ Other: _____

HPV ☐ Negative ☐ Positive Type: _____

☐ Cytology/Pathology Review Completed

6. FINAL EVALUATION

☐ Negative for Dysplasia

☐ HPV/Condyloma ☐ Benign Atypia

☐ CIN 1 ☐ CIN 2 ☐ CIN 3 ☐ AIS

☐ Microinvasive SCC ☐ Malignant SCC

☐ Adenocarcinoma ☐ VAIN 1 ☐ VAIN 2/3

☐ Other: _____

7. RECOMMENDATIONS (Complete only 7a, 7b, or 7c)

Date (YYYYMMDD)

7a. 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: _____

7b. Return to Primary Care

Pap Test in:

☐ 12 Months ☐ 36 Months ☐ _____ Months

☐ Gynecology Referral (Primary Provider to Arrange)

re: _____

7c. Other Recommendation

☐ Patient Referred to BC Cancer

☐ No Further Screening or Colposcopy Required

re: _____

☐ Gynecological Consult (Colposcopist to Arrange)

☐ Hysterectomy Discussion

☐ Other: _____

HPV Vaccine

☐ HPV Vaccine Recommended

☐ HPV Vaccine Rx Provided

Attention Provider

☐ Inform Patient of Result

☐ Patient Aware of Result

_____

Colposcopist Signature