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|U)

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) _____

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

☐ HSIL Mod ☐ HSIL Severe ☐ Malignant Sq ☐ Malignant GI

☐ AGC NOS ☐ AGC-FN ☐ AIS ☐ Unsat

☐ DES Exposure

☐ 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

HPV Test in:

☐ 12 Months ☐ _____ Months

Co-Test (Cytology & HPV Test) in:

☐ 12 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

INFORMATION ON THIS FORM IS CONFIDENTIAL
IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604)708-2114

40140

Please press firmly to ensure that all 3 copies of this form are legible
Fax copy to Cervix Screening Program: 1 (604) 297-9327

Patient Identifiers: A label can be used if legible and affixed in the upper right corner, otherwise complete all fields. If a legible hospital label is used you do not need to enter the patient name, date of birth, or PHN.
Primary Provider: Indicate the patients primary care provider, this is often the same as the referring provider.
Referring Provider: Indicate the provider that referred the patient for Colposcopy.

1. History: Ensure that all yes/no boxes are completed. *(Parity, LMP, previous treatment, HPV year and type, and other history)* will not be captured by the Cervix Screening Program.

2. Reason for Colposcopy: Choose the **most** recent/relevant reason for colposcopy (e.g., if a patient had incidental cytology completed between surveillance visits post treatment, then list "Treatment Follow-Up" as reason for colposcopy). An abnormal screen takes precedence for analysis purposes if there are multiple reasons for colposcopy (e.g., if the patient has an abnormal cervical screen and a clinical abnormality, please select "Abnormal Screen" as the reason for colposcopy).
Abnormal Primary Screen: Choose one cytology result. If the result has multiple diagnoses, choose the most severe and indicate the date of the abnormal screen. If the patient is being referred for an abnormal primary HPV screen, choose HPV Positive, list the type, and choose if there were any accompanying cytology results.
DES Exposure: Choose if the patient has had DES exposure in utero.
Clinical Abnormality: Choose if the patient was referred to colposcopy for a clinical abnormality.
Repeat Colposcopy for: Choose if repeat colposcopy, and describe the reason for repeat colposcopy (e.g., not yet diagnosed).
Treatment Follow-Up: Choose the most relevant diagnosis being followed, multiple can be selected. Document the most recent treatment and visit number.
Other: If the reason for colposcopy is not listed, choose "Other" and describe the reason in the space provided.

3. Colposcopic Examination
Site Examed: Choose all sites examined during colposcopy. More than one site can be chosen. However, do not check "Vagina" if this site was seen incidentally during colposcopic examination.
Adequacy: Choose if the colposcopic examine was "Adequate" or "Inadequate". If the exam is inadequate indicate the reason in the comments section.
Transformation Zone: Choose "Type 1", "Type 2" or "Type 3".
Biopsy: Choose if a biopsy was "Done" or "Not Done".
ECC: Choose if an ECC was "Done" or "Not Done".
Other Procedures: Choose if any other procedures were completed during colposcopy, more than one may be chosen.

4. Impression: Choose impression from exam of the most severe lesion seen. More than one impression may be chosen. *Record any additional information in the comments section.*

5. Results: Choose results (most severe) after the pathology and/or HPV results are received. More than one histopathology result can be chosen.

6. Final Evaluation: Choose the most severe diagnosis. If the result is not listed choose "Other" and describe in the space provided.

7. Recommendations: The patient must have one of the following recommendations: Colposcopy, Treatment, HPV Test, Cotest, Referred to BC Cancer, Gynecological Consult (colposcopist arranging), or No Further Screening or Colposcopy Required.
Return to Colposcopy Clinic: Choose whether it is for colposcopy or treatment.
- **Colposcopy:** Choose the interval: 6, 12, or fill in the number of months. Select "Yes" or "No" for whether the procedure is booked.
- **Treatment:** Choose the interval: 2 or fill in the number of months. Select "Yes" or "No" for whether the procedure is booked.

Return to Primary Care: If the patient is returning to primary care indicate the number of months from colposcopy discharge until the patient should be screened again. Select HPV (Self-screening kit will be mailed) or cotest (HPV and cytology testing) and select the interval: 12 or fill in the number of months. A recall notice will be sent when the patient is due.
Other Recommendation: For the following three choices, No recalls will be sent for patients until a subsequent HPV or Cytology result, Colposcopy Form or Treatment Form is submitted with recall recommendations.
- **Patient Referred to BC Cancer:** Choose if the patient has a diagnosis of cancer that requires gynecologic oncology.
- **Gynecological Consult:** Choose if you have referred the patient for gynecological consult and choose either "Hysterectomy Discussion" or "Other" and indicate the reason in the space provided.
- **No Further Screening or Colposcopy Required:** Only choose if patient no longer needs to return to treatment/colposcopy or primary care.

HPV Vaccine: Select if the HPV vaccine was recommended to the patient or if prescription was provided.
Attention Provider: Choose if you have informed the patient of their result or if the primary care provider is expected to inform the patient of their results.