40110

BC CANCER CERVIX SCREENING
Provincial Health Services Authority

COLPOSCOPY FORM

AFFIX CLIENT LABEL HERE

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

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. HISTORY

Parity_____ LMP_____

Pregnant ☐ Yes ☐ No

Postmenopausal ☐ Yes ☐ No HRT ☐ Yes ☐ No

Previous Treatment (eg LEEP) YYMM

_____ _____

_____ _____

_____ _____

HPV Vaccine 2+ doses ☐ Yes ☐ No Year_____Type_____

Current Smoker ☐ Yes ☐ No

Immunocompromised ☐ Yes ☐ No

Other History _____

2. REASON FOR COLPOSCOPY (Choose 1)

☐ **Abnormal Screen** Date (YYYYMMDD) _____

☐ Unsat ☐ ASC-US ☐ LSIL

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

☐ AGC NOS ☐ AGC-FN ☐ AIS ☐ Malignant Gl

☐ HPV+ Type _____

☐ **Clinical Abnormality** _____

☐ **Repeat Colpo for** _____

☐ **Treatment Follow-up** Year of Treatment_____Visit#_____

☐ CIN 2/3 ☐ AIS ☐ Cancer ☐ VAIN ☐ VIN

HPV ☐ Negative ☐ Positive Type _____

☐ **Other** _____

3. COLPOSCOPIC EXAMINATION

Site Examined ☐ Cervix ☐ Vagina ☐ Vulva

Adequacy ☐ Adequate ☐ Inadequate

SCJ Visibility ☐ Completely ☐ Partially ☐ Not Visible

Biopsy ☐ Done ☐ Not Done

ECC ☐ Done ☐ Not Done

Other Procedures

☐ Endometrial Biopsy ☐ Pap Test ☐ HPV Test

☐ Vaginal Biopsy ☐ Vulvar Biopsy

Diagram for lesion

BIOPSY SITE

Comments

4. IMPRESSION

☐ Negative for Dysplasia

☐ HPV/Condyloma ☐ Benign Atypia

☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ AIS

☐ Microinvasive SCC ☐ Malignant SCC

☐ Adenocarcinoma

☐ VAIN 1 ☐ VAIN 2/3 ☐ VIN 1 ☐ VIN 2/3

5. RESULTS

☐ Insufficient Samples ☐ 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

HPV ☐ Negative ☐ Positive Type _____

☐ Cytology/Pathology Review Completed

6. FINAL EVALUATION

☐ Negative for Dysplasia

☐ HPV/Condyloma ☐ Benign Atypia

☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ AIS

☐ Microinvasive SCC ☐ Malignant SCC

☐ Adenocarcinoma

☐ VAIN 1 ☐ VAIN 2/3 ☐ VIN 1 ☐ VIN 2/3

☐ Other _____

7. 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 _____

Return to Primary Care

☐ Pap Test in _____months ☐ Refer to Gynecology re: _____

☐ 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**

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