

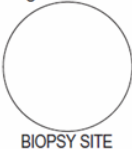
FAX COPY TO CERVIX SCREENING PROGRAM: 1 (604) 297-9327

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	Previous Treatment (eg LEEP) Y Y M M		
Parity _____ LMP _____			
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No			
Postmenopausal <input type="checkbox"/> Yes <input type="checkbox"/> No			
HRT <input type="checkbox"/> Yes <input type="checkbox"/> No	Current Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No		
HPV Vaccine 2+ Doses <input type="checkbox"/> Yes <input type="checkbox"/> No	Immunocompromised <input type="checkbox"/> Yes <input type="checkbox"/> No		
Year: _____ Type: _____	Other History: _____		

	REFERRING PROVIDER (MSC)	REFERRING PROVIDER LAST, FIRST	(If different from Primary Provider above)
2. REASON FOR COLPOSCOPY (Select one option below)			
<input type="checkbox"/> Abnormal Screen Date (YYYYMMDD) _____			
<input type="checkbox"/> Unsat	<input type="checkbox"/> ASC-US	<input type="checkbox"/> LSIL	<input type="checkbox"/> HPV Positive Type: _____
<input type="checkbox"/> ASC-H	<input type="checkbox"/> HSIL Mod	<input type="checkbox"/> HSIL Severe	<input type="checkbox"/> Malignant Sq
<input type="checkbox"/> AGC NOS	<input type="checkbox"/> AGC-FN	<input type="checkbox"/> AIS	<input type="checkbox"/> Malignant GI

3. COLPOSCOPIC EXAMINATION	Biopsy (Cervix)		
Site Examined	<input type="checkbox"/> Done <input type="checkbox"/> Not Done		
<input type="checkbox"/> Cervix <input type="checkbox"/> Vagina	ECC		
Adequacy (Cervix)	<input type="checkbox"/> Done <input type="checkbox"/> Not Done		
<input type="checkbox"/> Adequate <input type="checkbox"/> Inadequate	Other Procedure		
Transformation Zone	<input type="checkbox"/> Endometrial Biopsy <input type="checkbox"/> Pap Test		
<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type 3	<input type="checkbox"/> Vaginal Biopsy <input type="checkbox"/> HPV Test		

4. IMPRESSION		Diagram for lesion	Comments
<input type="checkbox"/> Negative for Dysplasia			
<input type="checkbox"/> HPV/Condyloma	<input type="checkbox"/> Benign Atypia		
<input type="checkbox"/> CIN1 <input type="checkbox"/> CIN2	<input type="checkbox"/> CIN3 <input type="checkbox"/> AIS		
<input type="checkbox"/> Microinvasive SCC	<input type="checkbox"/> Malignant SCC		
<input type="checkbox"/> Adenocarcinoma	<input type="checkbox"/> VAIN 1 <input type="checkbox"/> VAIN 2/3		

5. RESULTS		Date (YYYYMMDD)	
<input type="checkbox"/> Negative for Dysplasia	<input type="checkbox"/> Insufficient Samples		
<input type="checkbox"/> HPV/Condyloma	<input type="checkbox"/> Benign Atypia		
<input type="checkbox"/> CIN 1 <input type="checkbox"/> CIN 2 <input type="checkbox"/> CIN 3	<input type="checkbox"/> HSIL NOS <input type="checkbox"/> AIS		
<input type="checkbox"/> Microinvasive SCC	<input type="checkbox"/> Malignant SCC		
<input type="checkbox"/> Adenocarcinoma	<input type="checkbox"/> VAIN 1 <input type="checkbox"/> VAIN 2/3		
<input type="checkbox"/> Other: _____			
HPV <input type="checkbox"/> Negative <input type="checkbox"/> Positive Type: _____			
<input type="checkbox"/> Cytology/Pathology Review Completed			

7. RECOMMENDATIONS (Complete only 7a, 7b, or 7c)			
7a. Return to Colposcopy Clinic	Colposcopy in: Booked: <input type="checkbox"/> Yes <input type="checkbox"/> No	Treatment within: Booked: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> 6 Months <input type="checkbox"/> 12 Months <input type="checkbox"/> _____ Months	<input type="checkbox"/> 2 Months <input type="checkbox"/> _____ Months	
		Site: <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina	
		Type: <input type="checkbox"/> LEEP <input type="checkbox"/> Laser <input type="checkbox"/> Other: _____	

6. FINAL EVALUATION			
<input type="checkbox"/> Negative for Dysplasia			
<input type="checkbox"/> HPV/Condyloma	<input type="checkbox"/> Benign Atypia		
<input type="checkbox"/> CIN 1 <input type="checkbox"/> CIN 2 <input type="checkbox"/> CIN 3	<input type="checkbox"/> AIS		
<input type="checkbox"/> Microinvasive SCC	<input type="checkbox"/> Malignant SCC		
<input type="checkbox"/> Adenocarcinoma	<input type="checkbox"/> VAIN 1 <input type="checkbox"/> VAIN 2/3		
<input type="checkbox"/> Other: _____			

7b. Return to Primary Care			
Pap Test in:	<input type="checkbox"/> 12 Months <input type="checkbox"/> 36 Months <input type="checkbox"/> _____ Months	<input type="checkbox"/> Gynecology Referral (Primary Provider to Arrange)	re: _____
7c. Other Recommendation	<input type="checkbox"/> Patient Referred to BC Cancer	<input type="checkbox"/> Gynecological Consult (Colposcopist to Arrange)	
	<input type="checkbox"/> No Further Screening or Colposcopy Required	<input type="checkbox"/> Hysterectomy Discussion	
	re: _____	<input type="checkbox"/> Other: _____	

HPV Vaccine	Attention Provider		
<input type="checkbox"/> HPV Vaccine Recommended	<input type="checkbox"/> Inform Patient of Result		
<input type="checkbox"/> HPV Vaccine Rx Provided	<input type="checkbox"/> Patient Aware of Result		Colposcopist Signature

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