Referral Received:

**Triage Notes:** COLPOSCOPY USE ONLY

Booking Time Frame:____________

Pap #1:
Date of Pap Smear:____________
Results:____________

Pap #2 (if applicable):
Date of Pap Smear:____________
Results:____________

Cervix/Vulvar notes; Special requests:
____________
____________
____________

Triaged by:____________

**COLPOSCOPY CLINIC REFERRAL FORM Fax to 519-646-6377**

Patient:____________

Address____________

City____________Postal Code____________

Health Care #____________DOB____________

Telephone____________Cell____________

Family physician____________Telephone____________

Is an Interpreter required? No____Yes_____Language Requested:____________

Referring Provider:____________Provider Number:____________

Address:____________

Telephone Number:____________Fax Number:____________

**Fax & phone numbers must be provided so reports and appt details can be faxed to you.*

**Reason for Referral:**

- ☐ Abnormal Cytology/Pathology
- ☐ Condyloma
- ☐ Other
- ☐ Abnormal Cervix
- ☐ Vulva Abnormality
- ☐ Second Opinion

**Most recent Pap smear(s) & biopsy/swab/other lab results must accompany referral form.*

**Two (2) Pap smear results must be provided if LSIL or ASCUS.** ☐ ☐

**One (1) Pap smear result is sufficient if HSIL or AGUS** ☐

**Notes:**

**Special Requests:**

**Referring Physician's Signature:**____________Date:____________