Juravinski Hospital and Cancer Centre
HAMILTON HEALTH SCIENCES

Colposcopy Clinic Referral Form
Juravinski Hospital & Cancer Centre
711 Concession Street
PHONE: 905-574-8488 FAX: 905-575-2587

Please complete all sections of the referral and attach all pap smear results. Incomplete referrals will be returned. We will fax your office an appointment to communicate to your patient.

I. REFERRING PROVIDER INFORMATION INCLUDING BILLING NUMBER

Name (Please print or use provider stamp)

Family Physician (if different than referring provider):

II. PATIENT INFORMATION

Name:	Date of Birth (dd/mm/yyyy)	Home Phone
Address:		Cell Phone
OHIP #		Work Phone

Permission to contact patient directly ❑ Yes ❑ No

III. MOST RECENT PAP TEST RESULT *(Please attach all reports)*

URGENT (*within 2 weeks)*

- ❑ Malignant Cells on Pap Smear
- ❑ Atypical Glandular Cells of Endocervical Origin
- ❑ Atypical Glandular Cells Favour Endometrial Origin
- ❑ Atypical Glandular Cells Favour Neoplastia

HIGH PRIORITY
(within 4-6 weeks)

- ❑ ASC-H
- ❑ HSIL
- ❑ Atypical Glandular Cells Not otherwise specified

ROUTINE *(within 12 weeks)*

- ❑ ASCUS x2
- ❑ ASCUS over age 30 with positive HPV
- ❑ LSIL

OTHER *(triaged by clinic)*

- ❑ Abnormal Pathology (please indicate):
  - ❑ Carcinoma in situ
  - ❑ Vulvar Intraepithelial Neoplasia
  - ❑ Adenocarcinoma in situ
- ❑ Abnormal Cervical Lesion Confirmed by Physician
  Describe: _____
- ❑ Vulvar Lesion
  Describe: _____
- ❑ Other: _____

Has this patient had previous Colposcopy?
❑ Yes Date: _____ Location: _____
❑ No

IV. REFERRING PROVIDER SIGNATURE

Date (dd/mm/yyyy)	Signature: