ST JOSEPH'S HEALTH CARE LONDON

Referral Received:

**Triage Notes:** **COLPOSCOPY USE ONLY**

Booking Time Frame: _____

Date of HPV result: _____

Results: _____

Cytology: _____

Cervix/Vulvar notes, Special requests:

_____

_____

_____

Triaged by: _____/Date: _____

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

Patient first name (per health card): _____

Last name: _____

Address: _____

City: _____ Postal Code: _____

Health Card #: _____ DOB: _____

Telephone*_____ Cell*_____

**Please indicate if appointment details cannot be left on the patient's voicemail.**

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:**

☐ HPV Positive
☐ Abnormal Cervix
☐ Condyloma
☐ Visible Vulvar Abnormality*
☐ Vulvar dermatologic condition (ex. Lichens sclerosus/planus)
☐ Second Opinion/Other

*If Vulvar pain, indicate location of pain on vulva/labia

**Has this patient been seen in Colposcopy in the past?** ☐ No ☐ Yes

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

**Notes/Special Requests:**

_____

_____

_____

Referring Physician's Signature: _____ Date: _____