ST JOSEPH'S HEALTH CARE LONDON

Colposcopy Clinic Referral Form

Colposcopy Clinic
St. Joseph's Hospital
B4-507
268 Grosvenor St.
London, ON N6A 4V2
Telephone: 519 646-6100 ext. 64130
Fax: 519 646-6377

TRIAGE NOTES: *(Office use only)*:

Time frame: _____

Results: _____

_____

_____

Special request: _____

_____

_____

Signature: _____

PATIENT INFORMATION (please print)

Surname: _____ Given Name: _____

Date of birth: _____ Health card number: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate: _____ Date of referral (YYYY/M/D/): _____

REFERRING CLINICIAN INFORMATION

Name: _____ Physician Number: _____

Address: _____ City: _____ Postal Code: _____

Phone: _____ * Fax: _____ Email: _____

Signature: _____

***Note - fax and phone numbers must be provided so the physician's report can be auto-faxed to you.**

Is an interpreter required?: _____ ☐ Yes ☐ No Preferred language _____

Reason for referral:

☐ Abnormal cytology/pathology ☐ Abnormal Cervix ☐ Condyloma
☐ Vulva abnormality ☐ Other ☐ Second opinion

The most recent Pap smear(s) and biopsy/swab/other lab results must accompany this referral form.

Two Pap smear results must be provided if LSIL or ASCUS.

One Pap smear result is sufficient if HSIL or AGUS.

Notes: _____

_____

_____

PLEASE ADVISE THE PATIENT TO REVIEW ST. JOSEPH'S WEBSITE FOR MORE INFORMATION REGARDING THEIR VISIT www.sjhc.london.on.ca/colposcopy