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 ☐ Condyloma ☐ Other

☐ Abnormal Cervix ☐ Vulva Abnormality ☐ Second Opinion

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: _____