



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: