



Colposcopy Clinic Referral Form
 Booking TELEPHONE: 250-370-8884 FAX: 250-519-1551
 RJHD & T Building
 1952 Bay Street
 Victoria, BC V8R 1J8

Patient Information:		Medical Record Number	
Name: _____		Telephone	
DOB: _____			
Preferred Name: _____			
PHN: _____			
Referring Physician/Billing Number	Physician Phone/Fax Number	Family Physician (if different)	
Financial Responsibility <input type="radio"/> BC Resident – MSP <input type="checkbox"/> Other Province _____ <input type="checkbox"/> uninsured Services <input type="radio"/> Non-Resident Canada <input type="checkbox"/> Self <input type="checkbox"/> Armed Forces			
Cytology Result <input type="radio"/> Unsatisfactory Squamous <input type="radio"/> ASC-US <input type="radio"/> LSIL (Mild) <input type="radio"/> ASC-H <input type="radio"/> HSIL (Mod) <input type="radio"/> HSIL (Marked) <input type="radio"/> Malignant Glandular <input type="radio"/> AGC NOS <input type="radio"/> AGC Neoplastic <input type="radio"/> AIS <input type="radio"/> Malignant * ALL REFERRALS MUST INCLUDE CYTOLOGY RESULT	Other Reason for Referral <input type="radio"/> Clinical abnormality of the Cervix <input type="radio"/> DES <input type="radio"/> Other _____ _____ Cytology result out of Province? YES NO	Procedure Requested <input type="radio"/> Colposcopy <input type="radio"/> LEEP <input type="radio"/> Follow-up	Previous Visit to Clinic With <input type="radio"/> Dr Cohen <input type="radio"/> Dr Hancock <input type="radio"/> Dr Hunt <input type="radio"/> Dr Mazgani <input type="radio"/> Dr Quinlan
Pregnant YES NO Weeks _____	Allergies/Sensitivities NONE _____ _____ _____ _____	Special Needs _____ _____ _____ _____	
Appointment Date/Time			Patient Notified YES NO