

Tel No: 020 8510 7609 (Appointments)
Tel No: 020 8510 5039 (Colposcopy Nurses)
Tel No: 020 8510 5727 (Coordinator)
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The Colposcopy Department
Chatsworth House
Homerton University Hospital
Homerton Row, London E9 6SR

COLPOSCOPY REFERRAL PROFORMA

FAX TO: 020 8510 5723

PATIENT'S NAME: DOB:

ADDRESS:
..... POSTCODE:

HOSPITAL NO: NHS NO:

TEL NO: DAY: MOBILE:

HOME: EMAIL:

INTERPRETER NEEDED: YES / NO LANGUAGE:

DATE OF REFERRAL:/...../.....

- REASON FOR REFERRAL: Abnormal Screening Smear Vaginal Disease
 Abnormal Smear after Colposcopy Vulval Disease
 Clinically Suspicious Cervix Transfer from other Unit
 Suspicious Symptoms Other

PREVIOUS COLPOSCOPY: No Yes Where done?

Diagnosis:

Treatment:.....Date:.....

RECENT SMEAR TEST RESULTS:

- None/Pending Mild Dyskaryosis Glandular Neoplasia
(Please enclose a copy) Negative (Normal) Moderate Dyskaryosis ? Invasive SCC
 Inadequate/Unsatisfactory Severe Dyskaryosis Keratinised Cells
 Borderline

If **NOT** enclosing photocopy of Smear Result
 Date of Smear Test:
 Laboratory Number:
 Reporting Laboratory:.....

Comments:

PMH:

Contraception:

- Referral Symptoms: Contact bleeding Intermenstrual bleeding Postcoital bleeding
 Postmenopausal bleeding Vaginal discharge Polyp

Name of GP (If not referrer): GP's Postcode: GP's Tel No:

Name of Referrer: Tel No:

Address: Postcode:

Signature: Date:

