Colposcopy Clinic
Norfolk General Hospital
365 West Street
Simcoe, Ontario N3Y 1T7

Time frame:_____
Results:

Special Request:

Signature: _____

Colposcopy Clinic Referral Form

FAX TO # 519-429-6895

PATIENT INFORMATION (please print)

Surname: _____ Given Name: _____

Date of Birth: _____ Health card number: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Alternate: _____ Date of referral (YYYY/MM/DD)

REFERRING CLINICIAN INFORMATION

Name: _____ Physician Number: _____

Address: _____ City: _____Postal Code: _____

Phone: _____ *Fax: _____ Email: _____

***Note – fax and phone numbers MUST be provided so the physician's report can be faxed to you.**
COPY OF CONSULT LETTER MUST BE INCLUDED WITH REFERRAL

REASON FOR REFERRAL

- ☐ Abnormal cytology / pathology
- ☐ Abnormal Cervix
- ☐ Condyloma
- ☐ Vulva abnormality
- ☐ Other
- ☐ Second Opinion

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

- ☐ **Two (2) Pap smear results must be provided if LSIL or ASCUS or one such report should be accompanied by a positive high risk HPV test.**
- ☐ **One (1) Pap smear result is sufficient if HSIL or AGUS.**

Notes: