Hamilton Niagara Haldimand
Brant Regional Cancer Program
Ontario Health (Cancer Care Ontario)

HNHB REFERRAL FOR COLPOSCOPY

Last Name:	First Name:
HIN/HCN/ OHIP #	DOB (yyyy/mm/dd):
Address:	
City/Province:	Postal Code:
Home Phone:	Cell Phone:
Email:	

Referral Date:

☐ **Juravinski Hospital**
Phone: 905-574-8488
Fax: 905-575-2587

☐ **West Lincoln Memorial Hospital**
Name of Physician:
Phone: 905-945-5757
Fax: 905-945-5858

☐ **Brantford General Hospital**
Name of Physician:
Phone:
Fax:

☐ **St. Josephs Healthcare**
Name of Physician:
Phone:
Fax:

☐ **Norfolk General Hospital**
Phone: 519-426-0130 x1277
Fax: 519-429-6884

☐ **Out of Hospital Clinic**
Name of Physician:
Phone:
Fax:

FOR A LIST OF COLPOSCOPISTS BY REGION SEE: https://hnhbscreenforlife.ca/information-for-health-care-providers/cervical-screening-resources/

Referring Physician: **Billing Number:** **Phone Number:** **Fax Number:**

Primary Care Physician:

Ontario Cervical Screening Program criteria (OCSP):

☐ HPV+ (16 or 18/45), **any cytology**

☐ HPV+ (other) and **high grade** cytology (please check one)

☐ HSIL	☐ AGC	☐ AEC-N	☐ ACC-E
☐ ASC-H,	☐ AGC-N	☐ AEC-NOS	☐ PDC
☐ AIS	☐ AGC-NOS,	☐ SCC	
☐ LSIL-H	☐ AEC	☐ ACC	

☐ HPV+ (other) x 2 samples, 2 years apart

☐ HPV+ 6-12 months hysterectomy with dysplasia present

☐ HPV+ age 70-74, any cytology

☐ HPV+ (any type) and History of AIS

☐ HPV+ (any type) and History of HSIL

☐ HPV+ (any type) and HPV+ discharge from colposcopy

☐ HPV "invalid" x 2 samples or Cytology "Unsatisfactory" x 2 samples

☐ Cervical lesion suspicious for dysplasia or cancer

Interim criteria during HPV transition:

☐ High grade cytology no HPV result

☐ Other:

Vulvovaginal dysplasia

Vulva:
☐ Vulvar intraepithelial neoplasia ☐ (VIN) 1 / ☐ 2 / ☐ 3 / ☐ LSIL / ☐ HSIL

☐ Vulvar lesion suspicious for dysplasia or cancer

Vagina:
☐ Vaginal intraepithelial neoplasia ☐ (VAIN) 1 / ☐ 2 / ☐ 3 / ☐ LSIL / ☐ HSIL

☐ Vaginal lesion suspicious for dysplasia or cancer

Please do not refer to colposcopy, and direct to local general gynecologist for the following:

- Abnormal bleeding
- Warts, cysts, polyps
- Incontinence, prolapse
- Pain, endometriosis
- Pruritus, discharge
- Lichen sclerosus/planus without evidence of lesions concerning for dysplasia or cancer

Relevant Tests to Date:

☐ **HPV** ☐ **Cytology** ☐ **Biopsy** ☐ **Imaging** ☐ **Results Attached**

Additional information:

Has this patient had previous Colposcopy? ☐ **Yes** ☐ **No.** **If Yes, Date:** _____ **Location:** _____

FOR INTERNAL USE ONLY

Reviewed by: Name: _____ Date: _____

Priority: