An EMIS version of this referral form is also available in EMIS resources: RP Referral for Colposcopy CEG (v1)

Homerton University Hospital NHS
NHS Foundation Trust

Please refer to colposcopy guidance **here** before referring

REFFERAL FORM FOR COLPOSCOPY

PATIENT DETAILS	
HOSPITAL NUMBER:	NHS NUMBER:
FIRST NAME:	SURNAME:
DATE OF BIRTH:	MOBILE NUMBER:
ADDRESS:	INTERPRETER NEEDED: Language:
REFERRAL DETAILS	
DATE OF REFFERAL:	
REFERRER: GP	
If you are referring from the GP, please complete following details: NAME: GP SURGERY NAME: GP ADDRESS: GP PHONE NUMBER:	
Reason for Referral:	**Referral Symptoms:**
Abnormal Screening Smear ☐ Clinically Suspicious Cervix ☐ Suspicious Symptoms ☐ Transfer from other unit ☐ Other ☐	Contact bleeding ☐ Intermenstrual bleeding ☐ Vaginal discharge ☐ Post-coital bleeding ☐
SMEAR TEST	Does patient have previous Colposcopy: Where was previous colposcopy done: Diagnosis: Treatment:
DATE OF SMEAR TEST: **<u>If there is NOT a copy of smear result, complete following</u>:** Laboratory Number: Reporting Laboratory:	

Recent Smear Test Results:		
None ☐	Borderline ☐	High Risk HPV ☐
Pending ☐	Mild Dyskaryosis ☐	Glandular Neoplasia ☐
Negative/Normal ☐	Moderate Dyskaryosis ☐	Invasive SCC ☐
Inadequate/Unsatisfactory ☐	Severe Dyskaryosis ☐	Keratinised Cells ☐

Additional Comments/Past Medical History/Contraception:

COLPOSCOPY USE:	ROUTINE/URGENT RECEIVED DATE: SIGNED:

CLEAR | **Please refer via eRS** | SAVE | PRINT | CLOSE | SEND