COLPOSCOPY PROGRAM REFERRAL FORM

A program for patients with suspected lower genital tract neoplasia

Fax: 705-739-5657 Tel: 705-728-9090 ext 46795

Date of Referral (DD/MM/YYYY): _____

Referring Physician Information

Referring Physician | OHIP Billing #

( ) | ( )

Phone # | Fax #

Primary Care Physician Information

❑ Same as Referring Physician

Primary Physician | OHIP Billing #

( ) | ( )

Phone # | Fax #

Patient Information

Patient Name | Date of Birth (DD / MM / YYYY)

Street Address | ( ) Home Phone # | ( ) Business/Other Phone #

City, Province | Postal Code | Health Card # | Version | Expiry date

Reason for Referral

Date of Referral (DD/MM/YYYY): _____

Referral Reason (Diagnosis): _____

❑ New Referral ❑ Transfer care from outside RVH ❑ 2nd Opinion

❑ Repeat Referral

Clinical & Diagnostic Information

❑ Most recent cytology results (required)

❑ Clinical information

❑ Imaging (Ultrasound, CT Scan, MRI)

❑ Surgical Pathology

❑ Operative Note

❑ Other _____

Indication for colposcopic evaluation

❑ Abnormal cervical cytology

❑ Abnormal vaginal cytology

❑ HPV positivity

❑ DES exposure

❑ Other _____

❑ Cervical lesion

❑ Vaginal lesion

❑ Vulvar lesion

❑ Perianal lesion

Please note: This program provides care for patients suspected to have pre-invasive **lower genital tract neoplasia only**. If your patient requires a benign gynecology review, please refer directly to a gynaecologist. If you suspect malignancy, please refer directly to a gynaecologic oncologist.

Fax your completed form to 705-739-5657.

This patient remains under the care of the referring physician until seen by our program.

Please ensure your patient is aware of referral. Patients may receive first available appointment and will be contacted directly with appointment.