Erie St. Clair
Regional Cancer Program
Ontario Health (Cancer Care Ontario)

Colposcopy Referral Form

Notes:

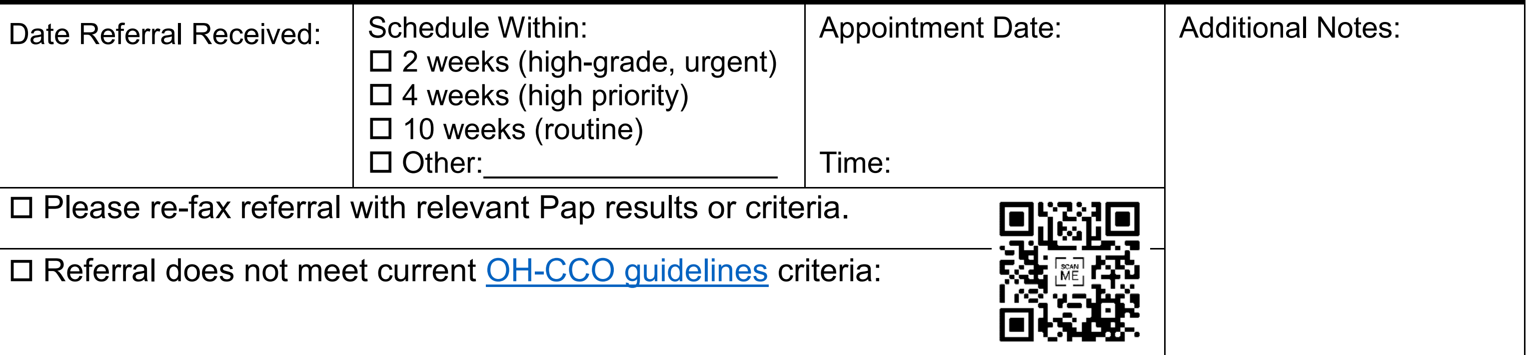
- Please use this form to indicate reason for referral to Colposcopy.
- Incomplete referral forms, including those without Pap test results attached, will not be processed.
- **Referrals should be sent within one week of the result date to allow for appropriate triaging and booking.**

PATIENT INFORMATION (please print)		
Name:	DOB:	Health Card #: Version Code:
Home #:	Alt. #:	Address:

COLPOSCOPY REQUIRED	**COLPOSCOPY POSSIBLY INDICATED**
☐ **High-grade result (urgent): ASC-H / HSIL / AGC / AIS [1 occurrence]**	☐ Post-coital bleeding [1 Pap test result]
☐ Low-grade result: ASCUS / LSIL [2 occurrences]	☐ Vulvar Disorders (lichen sclerosis, atypical areas)
☐ Suspicious lesion, cancer or dysplasia on (please circle): Cervix / Vulva / Vagina / Imaging	☐ Other (please describe):

PAST COLPO AND VACCINATION HISTORY	**HPV AND CERVICAL CANCER RISK FACTORS**	
Has this patient had a previous Colposcopy? ☐ Yes Date:______________ Location:_______________ ☐ No ☐ Unsure **Previous HPV Vaccine:** ☐ Yes ☐ No	☐ HPV DNA positive 16/18 ☐ Immunocompromised ☐ Smoking	☐ Previous Cone or LEEP ☐ Multiple sexual partners

REFERRING PROVIDER		**PRIMARY CARE PROVIDER**	
		☐ Same as Referring Provider	
Name:	OHIP Billing #:	Name:	OHIP Billing #:
Phone:	Fax:	Phone:	Fax:
Address:		Address:	
Signature: ________________________________			



TO BE COMPLETED BY COLPOSCOPY CLINIC STAFF ONLY			
Date Referral Received:	Schedule Within: ☐ 2 weeks (high-grade, urgent) ☐ 4 weeks (high priority) ☐ 10 weeks (routine) ☐ Other:__________________	Appointment Date: Time:	Additional Notes:
☐ Please re-fax referral with relevant Pap results or criteria.			
☐ Referral does not meet current OH-CCO guidelines criteria:			

Last Revised: May 7, 2024