fraserhealth

COLPOSCOPY BOOKING FORM

Instructions:
1. Call and make an appointment first
2. Complete form and then fax with Cytology Report
3. Inform Patient

JIM PATTISON OUTPATIENT CARE and SURGERY CENTRE
9750 - 140th Street,
Surrey, B.C. V3T 0G9

PATIENT SURNAME (legal) FIRST NAME (legal) OTHER NAMES	DOB (d/m/yyyy) AGE

ADDRESS	**PHONE** Res Cell
CITY PROVINCE POSTAL CODE	Bus Ext
REFERRING PHYSICIAN	DECISION DATE (d/m/yyyy)
PHONE#	(Report from BCCA read and referral sent)

CONSULTING SURGEON	DATE REFERRAL REC'D (d/m/yyyy)	**PROCEDURE DATE (d/m/yyyy)**
Dr		
PHONE#	(For specialists to fill out)	

PRIORITY

2B ☐	3A ☐	3B ☐
<2 wk	<1 mth	<2 mth
Suspect Malignancy	High Grade Dysplasia	

PROCEDURE

PROC. _____

CYTOLOGY#: LAST SMEAR DONE: POSITIVE PAP DATE:

PREVIOUS COLPOSCOPY: NO ☐ YES ☐ DATE & LOCATION: _____

SMEAR REPORT:

PATIENT ALERTS:

INTERPRETER REQ'D ☐ IF YES, LANGUAGE: _____

BOOKING FORM RECEIVED (d/m/yyyy): _____