



fraserhealth

COLPOSCOPY BOOKING FORM



AMXX102461B

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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 <input type="checkbox"/> <2 wk Suspect Malignancy	3A <input type="checkbox"/> <1 mth High Grade Dysplasia	3B <input type="checkbox"/> <2 mth	
PROCEDURE				
PROC. _____				
CYTOLOGY#:		LAST SMEAR DONE:	POSITIVE PAP DATE:	
PREVIOUS COLPOSCOPY: NO <input type="checkbox"/> YES <input type="checkbox"/> DATE & LOCATION: _____				
SMEAR REPORT:				

PATIENT ALERTS:				
INTERPRETER REQ'D <input type="checkbox"/> IF YES, LANGUAGE: _____				
BOOKING FORM RECEIVED (d/m/yyyy): _____				