



Referral Date:			
Patient Demographics:			
Last Name:		First Name:	
Birth Date:		SMH MRN (J#):	
Primary Phone No.: ()		Alternate Phone No.: ()	
OHIP No.:			
COLPOSCOPISTS			
<input type="checkbox"/> 1 ST Available	<input type="checkbox"/> Dr. S. Im	<input type="checkbox"/> Dr. A. Simpson	<input type="checkbox"/> Dr. E. Mocarski
<input type="checkbox"/> Dr. A. Satkunaratham	<input type="checkbox"/> Dr. E. Shore	<input type="checkbox"/> Dr. W. Steinberg	<input type="checkbox"/> Dr. M. Yudin
<input type="checkbox"/> Dr. D. Robertson	<input type="checkbox"/> Dr. M. Christakis		
REASON FOR REFERRAL TO COLPOSCOPY:			
<input type="checkbox"/> LSIL ASCUS (2 occurrences – fax both)		<input type="checkbox"/> Post-coital bleeding (1 pap result)	
<input type="checkbox"/> HSIL ASC-H AGC AIS (1 occurrence)		<input type="checkbox"/> Suspicious lesion for cancer or dysplasia on (circle): Cervix / Vulva / Vagina / Imaging	
<input type="checkbox"/> Vulvar Disorders (condylomas, lichen sclerosus, atypical areas)		<input type="checkbox"/> Other (describe)	
<p>Fax referral with patient's results to the Colposcopy Clinic The Colposcopy clinic will call the patient with an appointment date/time and location if the referral is accepted FOR YOUR REFERENCE, COLPOSCOPY SCREENING INFORMATION IS AVAILABLE AT: WWW.CANCERCARE.ON.CA/SCREENFORLIFE</p>			
VULVA SPECIALISTS			
<input type="checkbox"/> 1 ST Available			
REASON FOR REFERRAL TO VULVA:			
<input type="checkbox"/> Vulvar pain			
<input type="checkbox"/> Vulvar itch		<input type="checkbox"/> Vulvar skin changes	
<input type="checkbox"/> Dyspareunia		<input type="checkbox"/> Other (describe)	
REFERRING PHYSICIAN			
Referring Physician/Address (print):		Telephone:	
OHIP Billing #:		Fax:	Signature _____
TO BE COMPLETED BY COLPOSCOPY CLINIC STAFF			
Urgency:	<input type="checkbox"/> within 2 weeks	<input type="checkbox"/> 4 weeks	<input type="checkbox"/> 12 weeks
			<input type="checkbox"/> next available
Appointment with Dr:		Date:	Time:
<input type="checkbox"/> Please re fax referral with relevant pap results or criteria		<input type="checkbox"/> Referral does not meet current criteria as per CCO guidelines:	
VULVA ONLY: <input type="checkbox"/> Vulva 1 <input type="checkbox"/> Vulva 2			
Referral Triage Physician: Dr:			Date:

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