Trillium Health Partners
Better Together

COLPOSCOPY Clinic Referral Form

Trillium Health Partners - Credit Valley Hospital
2200 Eglington Avenue West, Mississauga ON L5M2N1
Phone: (905) 813-3862
Fax referrals to: (905) 813-4475

Last Name: _____ First Name: _____

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

Health card #: _____

MRN #: _____

CSN #: _____

THP use only

Affix patient encounter label here/complete all fields if label not available.

PATIENT DEMOGRAPHICS:

Last Name: _____ First Name: _____ Date of Birth (DD/MM/YYYY): _____/_____/_____

Health Card #: _____ Legal Sex: ☐ Female ☐ Male ☐ Non-Binary ☐ Unknown ☐ X

Address: _____ City: _____ Province: _____ Postal Code: _____

Telephone number: _____ Mobile number: _____ Email Address: _____

Reason for Referral

Cervix – Colposcopy:
Date of Screening
(DD/MM/YY): ____/____/____

Date of prior screening (if relevant)
(DD/MM/YY): ____/____/____

HPV Result:

☐ HPV 16 +

☐ HPV 18/45 +

☐ HPV Other

Pap Cytology:

☐ NILM/ASCUS/LSIL

☐ HSIL/ASC-H/LSIL-H/AIS

☐ AGC-N/NOS, AEC-N/NOS, SCC, ACC

☐ Other: _____

Cervix – other:

☐ Cervical lesion suspicious for malignancy/carcinoma (please describe in comments)

Vulva

☐ Vulvar intraepithelial neoplasia (VIN)

☐ LSIL ☐ HSIL

☐ Vulvar lesion suspicious for malignancy/carcinoma (please describe in comments)

Vagina

☐ Vaginal intraepithelial neoplasia (VAIN)

☐ LSIL ☐ HSIL

☐ Vaginal lesion suspicious for malignancy/carcinoma (please describe in comments)

Comments:

Has this patient had previous Colposcopy? ☐ Yes ☐ No

Date: _____ Location: _____ Previous care provider for colposcopy: _____

☐ **Results/consultation notes attached**

Referrals to colposcopy will not be accepted for the following concerns: Please refer to general gynecology

- Post-menopausal bleeding
- Uncomplicated Lichen sclerosis/planus
- Condylomas
- Post-coital bleeding/ectropion
- Vulvovaginal pruritus/discharge
- Polyps (cervical or endometrial)
- Bartholin's cyst

FOR INTERNAL USE ONLY

Reviewed by: _____ **Date:** _____ **Category** ☐ **1** ☐ **2** ☐ **3** ☐ **4** ☐ **5**

REFERRING PROVIDER:
Name of Referring Provider (Last Name, First Name- as listed in CPSO): _____

Address: _____ City: _____ Province: _____ Postal Code: _____

Phone number: _____ Fax number: _____ CPSO #: _____ Billing (OHIP) #: _____

Signature: _____ Date: _____