University College London Hospitals NHS
NHS Foundation Trust

Colposcopy Clinic Fax Number: 020 7383 2843
Email: ucl-tr.colposcopy@nhs.net

COLPOSCOPY REFERRAL FORM

Date of referral:		**Date of this smear:**	
NHS Number:		**Lab ID for smear:**	
Patients Surname:		**Patients Forename:**	
Address: (Including Postcode)		**Date of Birth:**	
		Daytime or Mobile telephone number:	
Name & Address of referring Doctor:		**GP's Name & Telephone number:**	

Reasons for Referral:

- ☐ Abnormal Screening & Opportunistic Smear
- ☐ Cervix Suspicious of Cancer – **Send target proforma**
- ☐ Unusual Appearance to Cervix – give details in box →
- ☐ Biopsy Showing CIN – give details in box →
- ☐ Suspicious Symptoms – give details in box →
- ☐ Vaginal Disease
- ☐ Vulval Disease
- ☐ Other, give details →

Smear Test Results:

- ☐ None Pending
- ☐ Negative/Normal
- ☐ Inadequate
- ☐ Other
- ☐ Borderline Changes
- ☐ Low Grade Dyskaryosis/CIN1
- ☐ High Grade Dyskaryosis (moderate)/CIN2
- ☐ High Grade Dyskaryosis (severe)/CIN3
- ☐ Glandular Neoplasia
- ☐ ? Invasion

High Risk HPV: ☐ Detected ☐ Not tested ☐ Not Available

If smear test inadequate, instrument used: ☐ Not Known ☐ LBC ☐ Brush ☐ Spatula ☐ Both

Laboratroy Smear ID:
(If UCLMS)

Laboratory Name:
(If not UCLMS)

Comments:
Eg Previous treatment for CIN;
Relevant medical history;
Relevant previous smears;

☐ Is an interpreter required? If yes, which Language?

For hospital use only: ☐ Within 2 weeks ☐ Urgent ☐ Routine

Clinical Priority	? Cancer	CIN2/3 <4wks	<CIN1; <8wks

*If you have any query about a referral or an appointment, please telephone the Colposcopy Coordinator on **020 34476597**.*