QUINTE HEALTH – DEPARTMENT OF SURGERY
COLPOSCOPY SHORT STAY FORM

CLINIC NUMBER:	CYTOLOGY ID #
REFERRING PHYSICIAN:	FAMILY PHYSICIAN:
EXAM DATE:	

HISTORY

Age at 1st pregnancy __________ Years

Gravidity ______ Parity _____ 20%

LMP ___________________________
dd mm yy

Pregnant □ Yes □ No EGA ______wks

Previous # m m d d y y
☐ LEEP __________ ___________
☐ Cone __________20% ___________
☐ Laser __________ ___________
☐ Cryo __________ ___________
☐ Hysterectomy ___________

HPV Vaccine 2+ doses □ YES □ NO ______ _20%_
yy Type

Current Smoker ☐ Yes ☐ No ________cigs/day

Immunocompromised ☐ Yes ☐ No

Hx of Condyloma ☐ Yes ☐ No

Menopausal ☐ Yes ☐ No HRT ☐ Yes ☐ No

REASON FOR COLPOSCOPY

Referral Cytology

☐ Unsatisfactory ☐ Malignant Squamous
☐ ASC-US
☐ LSIL ☐ AGC NOS
☐ ASC-H ☐ AGC Neoplastic
☐ HSIL – (Mod) ☐ AIS
☐ HSIL – (Marked) ☐ Malignant Glandular

Treatment Follow-up	Visit	HPV Status Today
☐ LEEP	☐ #1	
☐ Cone	☐ #2	☐ -ve
☐ Laser	☐ #3	☐ +ve
☐ Other	☐ #4	☐ Not Done

____

Other

☐ Clinical Abnormality ☐ VIN
☐ High Risk HPV Type ☐ VAIN
☐ Bleeding NYD ☐ Condyloma
☐ Other ________________________________

COLPOSCOPIC EXAMINATION

Site Examined ☐ Cervix ☐ Vagina ☐ Vulva

Able to Evaluate ☐ Yes ☐ No

Other Procedures ☐ Endometrial Biopsy ☐ Pap Test ☐ HPV Test ☐ Vaginal Biopsy ☐ Vulvar Biopsy

Impression

Satisfactory ☐ Yes ☐ No

☐ Negative for Dysplasia
☐ Benign Atypia
☐ HPV/Condyloma
☐ LSIL
☐ HSIL – Mod
☐ HSIL – Marked
☐ AIS/CIS
☐ Mircoinvasion
☐ Malignant

☐ VIN 1 ☐ VIN 2/3

☐ VAIN 1 ☐ VAIN 2/3

Biopsy ☐ Done ☐ Not Done

ECC ☐ Done ☐ Not Done

☐ Insufficient Samples
☐ Negative for Dysplasia
☐ CIN 1 - Mild
☐ CIN 2 - Mod
☐ CIN 3 - Severe
☐ CIS
☐ AIS
☐ Microinvasion
☐ Malignant

☐ VIN 1 ☐ VIN 2/3

☐ VAIN 1 ☐ VAIN 2/3
☐ Squamous ☐ Glandular

FINAL DIAGNOSIS

☐ Negative for Dysplasia
☐ CIN 1 – (Mild
☐ CIN 2 – (Mod)
☐ CIN 3 – (Severe)
☐ CIS
☐ AIS
☐ Microinvasion
☐ Malignant
☐ Squamous ☐ Glandular

☐ VIN 1 ☐ VIN 2/3
☐ VAIN 1 ☐ VAIN 2/3
☐ Other

____

RECOMMENDATIONS ______________________
DD MM YY

☐ Return to Regular Pap Screening 12 months
☐ Repeat Pap Test in ________months
☐ Repeat Colposcopy in ________ months
☐ Laser vaporization ☐ Cervix ☐ Vagina ☐ Vulva
☐ Excisional Treatment ☐ LEEP ☐ Cone
☐ Hysterectomy ☐ Refer to BCCA
☐ Cytology Review ☐ QA Review
☐ HPV Vaccine recommended

Attn: Referring Physicians

☐ Appt. Booked _________________________
DD MM YY
☐ Please Book Appt.
☐ We will inform patient of result
☐ Please inform patient of result

Diagram for Lesion

BIOPSY SITE

Other Comments

MSC#

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SIGNATURE