



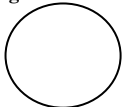

**QUINTE HEALTH – DEPARTMENT OF SURGERY
COLPOSCOPY SHORT STAY FORM**

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

HISTORY		
Age at 1 st pregnancy _____ Years	Previous # _____ m m d d y y	HPV Vaccine 2+ doses <input type="checkbox"/> YES <input type="checkbox"/> NO _____ yy Type <u>20%</u>
Gravidity _____ Parity _____ 20%	<input type="checkbox"/> LEEP _____	Current Smoker <input type="checkbox"/> Yes <input type="checkbox"/> No _____cigs/day
LMP _____	<input type="checkbox"/> Cone _____ 20%	Immunocomprised <input type="checkbox"/> Yes <input type="checkbox"/> No
dd mm yy	<input type="checkbox"/> Laser _____	Hx of Condyloma <input type="checkbox"/> Yes <input type="checkbox"/> No
Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No EGA _____wks	<input type="checkbox"/> Cryo _____	Menopausal <input type="checkbox"/> Yes <input type="checkbox"/> No HRT <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Hysterectomy _____	

REASON FOR COLPOSCOPY			
Referral Cytology	Treatment Follow-up	Visit	HPV Status Today
<input type="checkbox"/> Unsatisfactory <input type="checkbox"/> Malignant Squamous <input type="checkbox"/> ASC-US <input type="checkbox"/> LSIL <input type="checkbox"/> AGC NOS <input type="checkbox"/> ASC-H <input type="checkbox"/> AGC Neoplastic <input type="checkbox"/> HSIL – (Mod) <input type="checkbox"/> AIS <input type="checkbox"/> HSIL – (Marked) <input type="checkbox"/> Malignant Glandular	<input type="checkbox"/> LEEP <input type="checkbox"/> Cone <input type="checkbox"/> Laser <input type="checkbox"/> Other	<input type="checkbox"/> #1 <input type="checkbox"/> #2 <input type="checkbox"/> #3 <input type="checkbox"/> #4	<input type="checkbox"/> -ve <input type="checkbox"/> +ve <input type="checkbox"/> Not Done
Other			
<input type="checkbox"/> Clinical Abnormality <input type="checkbox"/> VIN <input type="checkbox"/> High Risk HPV Type <input type="checkbox"/> VAIN <input type="checkbox"/> Bleeding NYD <input type="checkbox"/> Condyloma <input type="checkbox"/> Other _____			

COLPOSCOPIC EXAMINATION		
Site Examined <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva Able to Evaluate <input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Endometrial Biopsy <input type="checkbox"/> Pap Test <input type="checkbox"/> HPV Test Procedures <input type="checkbox"/> Vaginal Biopsy <input type="checkbox"/> Vulvar Biopsy	FINAL DIAGNOSIS <input type="checkbox"/> Negative for Dysplasia <input type="checkbox"/> CIN 1 – (Mild) <input type="checkbox"/> CIN 2 – (Mod) <input type="checkbox"/> CIN 3 – (Severe) <input type="checkbox"/> CIS <input type="checkbox"/> AIS <input type="checkbox"/> Microinvasion <input type="checkbox"/> Malignant <input type="checkbox"/> Squamous <input type="checkbox"/> Glandular <input type="checkbox"/> VIN 1 <input type="checkbox"/> VIN 2/3 <input type="checkbox"/> VAIN 1 <input type="checkbox"/> VAIN 2/3 <input type="checkbox"/> Other _____	RECOMMENDATIONS _____ DD MM YY <input type="checkbox"/> Return to Regular Pap Screening 12 months <input type="checkbox"/> Repeat Pap Test in _____months <input type="checkbox"/> Repeat Colposcopy in _____ months <input type="checkbox"/> Laser vaporization <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Excisional Treatment <input type="checkbox"/> LEEP <input type="checkbox"/> Cone <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Refer to BCCA <input type="checkbox"/> Cytology Review <input type="checkbox"/> QA Review <input type="checkbox"/> HPV Vaccine recommended
Impression Satisfactory <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Negative for Dysplasia <input type="checkbox"/> Benign Atypia <input type="checkbox"/> HPV/Condyloma <input type="checkbox"/> LSIL <input type="checkbox"/> HSIL – Mod <input type="checkbox"/> HSIL – Marked <input type="checkbox"/> AIS/CIS <input type="checkbox"/> Microinvasion <input type="checkbox"/> Malignant <input type="checkbox"/> VIN 1 <input type="checkbox"/> VIN 2/3 <input type="checkbox"/> VAIN 1 <input type="checkbox"/> VAIN 2/3	Biopsy <input type="checkbox"/> Done <input type="checkbox"/> Not Done ECC <input type="checkbox"/> Done <input type="checkbox"/> Not Done <input type="checkbox"/> Insufficient Samples <input type="checkbox"/> Negative for Dysplasia <input type="checkbox"/> CIN 1 - Mild <input type="checkbox"/> CIN 2 - Mod <input type="checkbox"/> CIN 3 - Severe <input type="checkbox"/> CIS <input type="checkbox"/> AIS <input type="checkbox"/> Microinvasion <input type="checkbox"/> Malignant <input type="checkbox"/> VIN 1 <input type="checkbox"/> VIN 2/3 <input type="checkbox"/> VAIN 1 <input type="checkbox"/> VAIN 2/3 <input type="checkbox"/> Squamous <input type="checkbox"/> Glandular	Attn: Referring Physicians <input type="checkbox"/> Appt. Booked _____ DD MM YY <input type="checkbox"/> Please Book Appt. <input type="checkbox"/> We will inform patient of result <input type="checkbox"/> Please inform patient of result

Diagram for Lesion  BIOPSY SITE		Other Comments _____ MSC# _____	_____ SIGNATURE
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