_____Hospital

Colposcopy Clinic (New Patient Details)

Date of appointment / /

Please affix addressograph label if available

Health& Care No._____

Patient Name _____

Date of Birth _____

Occupation _____

Telephone No. _____

Name and Status of colposcopist

Smoker Yes / No

Reason for referral

Age……. Parity…….

Previous Abnormal Smear / Colposcopy/ Treatment

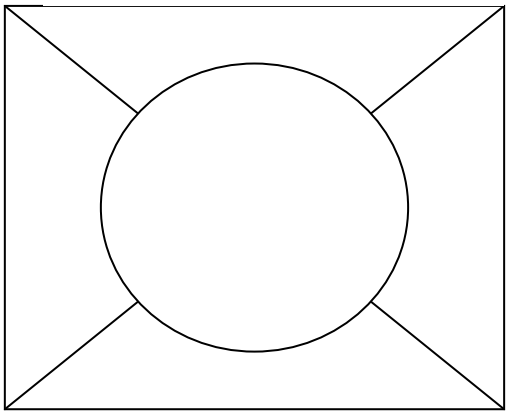
Last Normal Smear Date / /

Date of Referral Smear / / Smear Result

Cycle…… LNMP……PCB…… IMB…… Contraception ……

Discharge…… PMH……

COLPOSCOPY FINDINGS



Drugs

Allergies

Chlamydia swab

Smear

Colposcopy Satisfactory

Scj Seen

Lesion present

Biopsy (o'clock)

Colposcopic Opinion

Histological Diagnosis

COMMENTS

Outpatient Treatment

LLETZ / Cold Coagulation / Laser / Excision / Ablation

Local Anaesthetic ☐

Consent

Procedure Explained / Informed Consent ☐ *(Please Tick)*

Verbal /Written

(Delete as necessary)

Signature: ……

PLANNED ACTION

Discharge

Review

Inpatient Treatment / Colposcopy / Smear only

GA / LA

Date / /