_____Hospital
Colposcopy Clinic
(Review Patient Details)

Please affix addressograph label if available

H&C Number _____

Patient Name _____

Date of Birth _____

Occupation _____

Telephone No. _____

Date of appointment / /

Name and Status of colposcopist

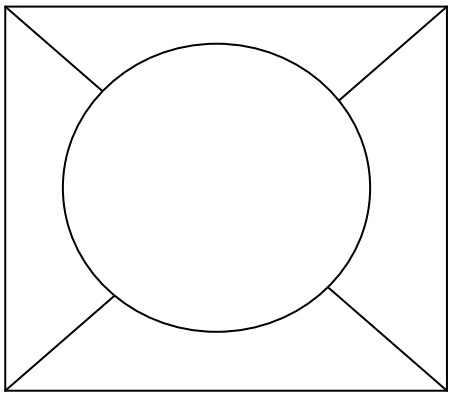
LMP

Reason for review

Problems at last visit/after Rx

Previous Abnormal Smear / Colposcopy/ Treatment

Last Normal Smear **Date** / /



Smear
Colposcopy Satisfactory
Scj Seen
Lesion present
Biopsy (o'clock)

Colposcopic Opinion

Histological Diagnosis

COMMENTS

_____

_____

_____

<u>Outpatient Treatment</u>
LLETZ / Cold Coagulation /
Laser / Excision / Ablation

Local Anaesthetic

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

Verbal /Written
(Delete as necessary)

PLANNED ACTION

Discharge
Review

Inpatient Treatment / Colposcopy / Smear only

GA / LA

Date / /

Signature: .....

Letter to Cytology