CervicalCheck
THE NATIONAL CERVICAL SCREENING PROGRAMME

CervicalCheck Colposcopy Referral Form

National Cancer Screening Service

POST or **FAX** this **FORM** to **ONLY ONE** of the CervicalCheck Colposcopy Services to avoid duplication. (**Please ✓**)

	Service	Tel	Fax
☐	AMNCH – Tallaght Colposcopy Service	Tel: 01 4144752	Fax: 01 4144725
☐	Cork Colposcopy Service	Tel: 021 4923300	Fax: 021 4923301
☐	Coombe Colposcopy Service	Tel: 01 4085768	Fax: 01 408 5727
☐	Dundalk – North East Regional Colposcopy Service	Tel: 042 9364222	Fax: 042 9389850
☐	Galway Colposcopy Service	Tel: 091 544536	Fax: 091 514021
☐	Kerry Colposcopy Service	Tel: 066 7184189	Fax: 066 7103108
☐	Letterkenny Colposcopy Service	Tel: 074 9104497	Fax: 074 9123635
☐	Limerick Colposcopy Service	Tel: 061 483111	Fax: 061 483112
☐	Mayo Colposcopy Service	Tel: 094 9042631	Fax: 094 9042683
☐	NMH Colposcopy Service	Tel: 01 6373454	Fax: 01 637 3191
☐	Rotunda Colposcopy Service	Tel: 01 8176841	Fax: 01 8171733
☐	Sligo Colposcopy Service	Tel: 071 9136818	Fax: 071 9174709
☐	South Tipperary Colposcopy Service	Tel: 052 6177983	Fax: 052 6177011
☐	Waterford Colposcopy Service	Tel: 051 842067	Fax: 051 848800
☐	Wexford Colposcopy Service	Tel: 053 9153024	Fax: 053 9153078

Patient Details

Surname:

First Name: Date of Birth:

Address:

Mobile: Landline:

Consent to text reminder of appointment: ☐ Yes ☐ No

First Language: Interpreter Required: ☐ Yes ☐ No

Special Needs Assistance: ☐ Yes ☐ No

PPSN: CSP ID:

Mother's Maiden Name: Surname at Birth:

Referring General Practitioner Details

Name:

Address:

Telephone:

Fax:

GP Signature:

MCRN:

Date:

Referral Information

Reason for Referral: ☐ Abnormal Smear ☐ Suspicious Cervix

CervicalCheck Smear: ☐ Yes ☐ No

Referral Smear Details:

Date of Smear: Result of Smear:

Accession Number: Reporting Laboratory:

Please attach copy of the smear report with this referral.

Previous Smear History:

Previous Colposcopy: ☐ Yes ☐ No Where:

Previous Treatment: ☐ Yes ☐ No

Comments:

Clinical Findings:

Suspicious Cervix? ☐ Yes ☐ No

Details:

Past Medical History:

Past Surgical History:

Medications:

Allergies

Smoking status: ☐ Current smoker ☐ Ex-smoker ☐ Non-smoker

For Hospital Use

Service: ☐ Colposcopy ☐ Gynaecology

Colposcopy Service Triage: ☐ <2 weeks ☐ <4 weeks ☐ <8 weeks

Triaged by:

Date:

Date of referral received:

Date of appointment offered:

Reason patient did not accept first appointment offered:

Seen within Guidelines ☐ Yes ☐ No