Colposcopy Clinic Referral Form

Direct Fax Line: 01 4085727 / 01 4085470

Referring Doctor / Clinic_____

_____

Telephone Number._____ Email_____

Patient Name and Address_____

_____

Telephone No._____ Email_____

Mobile_____ Date of Birth:_____

Previous Coombe Patient: Yes No

Referral Indication: Abnormal Smear
Suspicious Cervix
Contact or Post Coital Bleeding

Please attach referral smear

Signed:_____

For office use only:	Appointment Date:_____