COLPOSCOPY REFERRAL FORM

PATIENT DETAILS	Name:	**Referring Clinician Information**
	Date of Birth: Age:	Name:
	OP/IP No:	Designation:
	Phone:	Signature: Date:
	County:	Contact details:
	Sub County	Date of Referral:
	Facility Name:	
CLINICAL INFORMATION and REFERRAL	**Patient Medical information** **Is the patient pregnant** ☐ Yes ☐ No. If "Yes" indicate the gestation _____ **Significant medical/surgical history**: _____ _____ **Allergies**: _____	
	Reason for Referral (tick all appropriate): ☐ Colposcopic Findings ☐ Gynaecological Review ☐ Biopsy (Histopathology) ☐ Treatment (LEEP) ☐ Oncology services ☐ palliative care/_____	