SCREENING PROGRAM FOR CERVICAL CANCER

Colposcopy Form

Telephone: 639-625-2132; 1-800-667-0017
Return to: 101-4545 Parliament Ave, Regina SK S4W 0G3
or fax 639-625-2197

Sask cancer AGENCY

Client name: _____ DOB: _____ HSN: _____

Address: _____

City/town: _____ Phone: _____

Consulting colposcopist: _____

Refering healthcare provider: _____

Family doctor: _____

History

- ☐ LNMP
- ☐ Pregnant Weeks: _____
- ☐ Postpartum Weeks: _____
- ☐ Menopause
- ☐ Previous laser Date: _____
- ☐ Previous LEEP Date: _____
- ☐ Hysterectomy Date: _____
- ☐ IUD
- ☐ Hormones
- ☐ Immunocompromised

Reason for Colposcopy

Cytology:

- ☐ ASC
- ☐ ASC-H
- ☐ LSIL
- ☐ HSIL
- ☐ Microinvasive
- ☐ Squamous cell carcinoma
- ☐ AGC - NOS
- ☐ AGC - Neoplastic
- ☐ AIS
- ☐ Adenocarcinoma
- ☐ Other: _____

Other:

- ☐ Follow up
- ☐ Clinical lesion
- ☐ DES exposure
- ☐ Other: _____

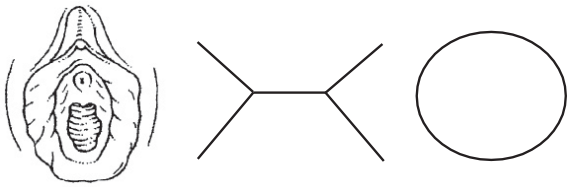
Colposcopic Impression

Satisfactory: ☐ Yes ☐ No

- ☐ Normal
- ☐ Metaplasia
- ☐ CIN 1
- ☐ CIN 2
- ☐ CIN 3
- ☐ HPV
- ☐ Invasive carcinoma
- ☐ Polyp
- ☐ Ectropion
- ☐ Lichen sclerosus
- ☐ Other: _____

Colposcopy Exam

Date of colposcopy: _____



Colposcopic Procedure

Cytology: ☐ Yes ☐ No

Colposcopic biopsy: ☐ Yes ☐ No

HPV testing: ☐ Yes ☐ No

Ecto/Endocervical: ☐ Yes ☐ No

HPV test of cure: ☐ Yes ☐ No

HPV-hr: ☐

ECC: ☐ Yes ☐ No

Other Clinical Information

Final Diagnosis and Post Procedural Plan

Diagnosis: _____

Plan:

- ☐ Repeat colposcopy in _____ months
- ☐ Repeat Pap test in _____ months
- ☐ LEEP
- ☐ Biopsy
- ☐ Hysterectomy
- ☐ Treatment for infection
- ☐ Discharge from colposcopy. Routine screening in _____ months
- ☐ Other: _____

_____ Date

_____ Colposcopist signature