

**COLPOSCOPY PATHOLOGY REQUISITION**

 Scanning Label or Accession # (*lab only*)

<b>Patient</b>	PHN		Expiry:		Date of Birth ( <i>dd-Mon-yyyy</i> )	
	Legal Last Name		Legal First Name		Middle Name	
	Alternate Identifier	Preferred Name		<input type="checkbox"/> Male	<input type="checkbox"/> Female	Phone
			<input type="checkbox"/> Non-binary	<input type="checkbox"/> Prefer not to disclose		
	Address		City/Town		Prov	Postal Code
<b>Provider (s)</b>	Authorizing Provider Name ( <i>last, first, middle</i> )				Copy to Name ( <i>last, first, middle</i> )	
	Address		Phone		Address	
	CC Provider ID	CC Submitter ID	Legacy ID	Phone		Phone
	Clinic Name			Clinic Name		Clinic Name
<b>Collection</b>	Date ( <i>dd-Mon-yyyy</i> )		Time ( <i>24 hr</i> )		Location	
					Collector ID	

<b>GYNECOLOGY HISTORY</b>	<b>PRIOR TREATMENT</b>	<b>FIRST COLPOSCOPY VISIT</b>
PREVIOUS PAP RESULT: _____  LNMP: ____/____/____ Cycle: Every ____ days <input type="checkbox"/> Hysterectomy (No Cervix) <input type="checkbox"/> Post Partum ____ weeks <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Breast feeding <input type="checkbox"/> IUD <input type="checkbox"/> Menopausal <input type="checkbox"/> Pregnant ____ weeks <input type="checkbox"/> OCP <input type="checkbox"/> HRT	____/____/____ <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Laser <input type="checkbox"/> LEEP <input type="checkbox"/> XRT <input type="checkbox"/> Cone <input type="checkbox"/> Other _____	<input type="checkbox"/> YES <input type="checkbox"/> NO  <b>COLPOSCOPIC IMPRESSION</b> <input type="checkbox"/> NEGATIVE <input type="checkbox"/> HPV / LSIL <input type="checkbox"/> HSIL

\* Each specimen container must be labelled with the patient's full first and last name and the exact specimen site.

<input type="checkbox"/> <b>BIOPSY</b> <input type="radio"/> Punch <input type="radio"/> Cone <input type="radio"/> Leep Location: ____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other: _____	LAB USE ONLY GROSS DESCRIPTION: Biopsy consists of fragments measuring: _____ mm greatest
<input type="checkbox"/> <b>BIOPSY</b> <input type="radio"/> Punch <input type="radio"/> Cone Location: ____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other: _____	LAB USE ONLY GROSS DESCRIPTION: Biopsy consists of fragments measuring: _____ mm greatest
<input type="checkbox"/> <b>BIOPSY</b> <input type="radio"/> Punch <input type="radio"/> Cone Location: ____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other: _____	LAB USE ONLY GROSS DESCRIPTION: Biopsy consists of fragments measuring: _____ mm greatest
<input type="checkbox"/> <b>BIOPSY</b> <input type="radio"/> Punch <input type="radio"/> Cone Location: ____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other: _____	LAB USE ONLY GROSS DESCRIPTION: Biopsy consists of fragments measuring: _____ mm greatest
<input type="checkbox"/> <b>CURETTINGS</b> <input type="checkbox"/> <b>BIOPSY</b> <input type="checkbox"/> Endocervix <input type="checkbox"/> Endometrium	LAB USE ONLY GROSS DESCRIPTION: Biopsy consists of fragments measuring: _____ mm greatest
<input type="checkbox"/> <b>CURETTINGS</b> <input type="checkbox"/> <b>BIOPSY</b> <input type="checkbox"/> Endocervix <input type="checkbox"/> Endometrium	LAB USE ONLY GROSS DESCRIPTION: Biopsy consists of fragments measuring: _____ mm greatest