Alberta Health Services

Colposcopy Referral
(Alberta Cervical Cancer Screening Program)

Fax completed referral and Pap test result to the Colposcopy Clinic indicated below.
For more information and a complete list of colposcopy clinics, please visit:
http://screeningforlife.ca/healthcare-providers-resources/

Patient Information

First Name	Last Name		Date of Birth *(yyyy-mm-dd)*
Address ☐ Verified	Postal Code	ULI/PHN	
City	Province	Home Phone ☐ Verified	Cell Phone ☐ Verified
English Proficiency ☐ Yes ☐ No *(specify)* _____			

Referral Information

Reason for Referral ☐ TOP CPG *http://www.topalbertadoctors.org/org/cpgs/19105*
☐ Lab Recommendation ☐ Follow up

Date of Pap *(yyyy-mm-dd)*	☐ Pap Test Result Attached *(this is required)*
Patient History	

Referring Physician Information *(please use stamp)*

Referral Date *(yyyy-mm-dd)*	Referring Prac ID	Stamp
Copy Report to *(print)*		

Colposcopy Clinic Information

Colposcopy Clinic *(select one clinic **only**)*	
Clinic Address	
Phone	Fax

To be completed by Colposcopy Clinic

Patient notified by: ☐ Phone ☐ Message ☐ Mail ☐ Other _____
Interpreter Required? ☐ Yes ☐ No If yes, Interpretation Service Line: 1-866-874-3972
Ordering Physician notified by: ☐ Phone ☐ Message ☐ Mail ☐ Fax

Date Referral Processed *(yyyy-mm-dd)*	Appointment Date *(yyyy-mm-dd)*	Appointment Time *(hh:mm)*
Location		