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 *(dd-Mon-yyyy)*

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 https://www.albertadoctors.org/media/xsolczf2/cervical-cancer-screening-guideline.pdf
- ☐ HPV Self-Sampling Immunocompetent Clinical pathway https://screeningforlife.ca/wp-content/uploads/HPV-SS-Clinical-Pathway.pdf
- ☐ HPV Self-Sampling Immunocompromised Clinical pathway https://screeningforlife.ca/wp-content/uploads/HPV-SS-Clinical-Pathway_Immunocompromised.pdf
- ☐ Lab Recommendation ☐ Follow up

Date of Pap *(dd-Mon-yyyy)*	☐ Pap Test Result Attached *(this is required)*
Date of HPV Self-Sampling *(dd-Mon-yyyy)*	Date of Triage Pap *(dd-Mon-yyyy)*

☐ HPV Self-Sampling and Triage Pap Results Attached *(this is required)*

Patient History

Referring Physician Information *(please use stamp)*

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

Location