



Colposcopy Pathology Requisition

Scanning Label or Accession # *(lab only)*

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

Gynecology History

Previous PAP result _____ LNMP *(dd-Mon-yyyy)* _____ Cycle every _____ days

Check all that apply:

- | | | |
|---|--|-------------------------------------|
| <input type="checkbox"/> Hysterectomy (no cervix) | <input type="checkbox"/> Pregnant _____ weeks | <input type="checkbox"/> Menopausal |
| <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Post Partum _____ weeks | <input type="checkbox"/> OCP |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Breast feeding | <input type="checkbox"/> HRT |

Prior Treatment

Treatment Date *(dd-Mon-yyyy)* _____

Type *(check all applicable)*

- | | | |
|---|--------------------------------|-------------------------------|
| <input type="checkbox"/> Cryotherapy | <input type="checkbox"/> Laser | <input type="checkbox"/> LEEP |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> XRT | <input type="checkbox"/> Cone |
| <input type="checkbox"/> Other <i>(specify)</i> _____ | | |

First Colposcopy visit? Yes No

Colposcopic Impression

- Negative HPV/LSIL HSIL

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

Specimen	Lab Use Only
<input type="checkbox"/> Biopsy <i>(specify)</i> <input type="checkbox"/> Punch <input type="checkbox"/> Cone <input type="checkbox"/> LEEP Location _____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other _____	Gross Description _____ Biopsy consists of fragments measuring _____ mm greatest
<input type="checkbox"/> Biopsy <i>(specify)</i> <input type="checkbox"/> Punch <input type="checkbox"/> Cone <input type="checkbox"/> LEEP Location _____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other _____	Gross Description _____ Biopsy consists of fragments measuring _____ mm greatest
<input type="checkbox"/> Biopsy <i>(specify)</i> <input type="checkbox"/> Punch <input type="checkbox"/> Cone <input type="checkbox"/> LEEP Location _____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other _____	Gross Description _____ Biopsy consists of fragments measuring _____ mm greatest
<input type="checkbox"/> Biopsy <i>(specify)</i> <input type="checkbox"/> Punch <input type="checkbox"/> Cone <input type="checkbox"/> LEEP Location _____ o'clock <input type="checkbox"/> Cervix <input type="checkbox"/> Vagina <input type="checkbox"/> Vulva <input type="checkbox"/> Other _____	Gross Description _____ Biopsy consists of fragments measuring _____ mm greatest
<input type="checkbox"/> Curetting <input type="checkbox"/> Biopsy <input type="checkbox"/> Endocervix <input type="checkbox"/> Endometrium	Gross Description _____ Biopsy consists of fragments measuring _____ mm greatest
<input type="checkbox"/> Curetting <input type="checkbox"/> Biopsy <input type="checkbox"/> Endocervix <input type="checkbox"/> Endometrium	Gross Description _____ Biopsy consists of fragments measuring _____ mm greatest