



POST this FORM to ONLY ONE of the CervicalCheck Colposcopy Services to avoid duplication. (Please ✓)

<input type="checkbox"/> AMNCH – Tallaght Colposcopy Service	Tel: 01 4144752	<input type="checkbox"/> Mayo Colposcopy Service	Tel: 094 9042631
<input type="checkbox"/> Cork Colposcopy Service	Tel: 021 4923300	<input type="checkbox"/> NMH Colposcopy Service	Tel: 01 6373454
<input type="checkbox"/> Coombe Colposcopy Service	Tel: 01 4085768	<input type="checkbox"/> Rotunda Colposcopy Service	Tel: 01 8176841
<input type="checkbox"/> Dundalk – North East Regional Colposcopy Service	Tel: 042 9364222	<input type="checkbox"/> Sligo Colposcopy Service	Tel: 071 9136818
<input type="checkbox"/> Galway Colposcopy Service	Tel: 091 544536	<input type="checkbox"/> South Tipperary Colposcopy Service	Tel: 052 6177983
<input type="checkbox"/> Kerry Colposcopy Service	Tel: 066 7184189	<input type="checkbox"/> Waterford Colposcopy Service	Tel: 051 842067
<input type="checkbox"/> Letterkenny Colposcopy Service	Tel: 074 9104497	<input type="checkbox"/> Wexford Colposcopy Service	Tel: 053 9153024
<input type="checkbox"/> Limerick Colposcopy Service	Tel: 061 483111		

Patient Details

Surname: _____

First Name: _____ Date of Birth: _____

Address: _____

Mobile: _____ Landline: _____

Consent to text reminder of appointment: Yes No

First Language: _____ Interpreter Required: Yes No

Special Needs Assistance: Yes No

PPSN: _____ CSP ID: _____

Mother's Maiden Name: _____ Surname at Birth: _____

Referring General Practitioner Details

Name: _____

Address: _____

Telephone: _____

GP Signature: _____

MCRN: _____

Date: _____

Referral Information

Reason for Referral: Abnormal Cervical Screening Test

CervicalCheck Cervical Screening Test: Yes No

Referral Cervical Screening Test Details:

Date of Cervical Screening Test: _____ Result of Cervical Screening Test _____

Accession Number: _____ Reporting Laboratory: _____

Please attach copy of the Cervical Screening Test report with this referral.

Previous Cervical Screening Test History:

Previous Colposcopy: Yes No Where: _____

Previous Treatment: Yes No

Comments: _____

Reason for Referral:

Clinical Indication

Clinical Findings (details):

Past Medical History:

Past Surgical History:

Medications:

Allergies

Smoking status: Current smoker

Ex-smoker Non-smoker

For Hospital Use

Service: Colposcopy Gynaecology

Colposcopy Service Triage: <2 weeks <4 weeks <8 weeks

Triaged by: _____

Date: _____

Date of referral received: _____

Date of appointment offered: _____

Reason patient did not accept first appointment offered: _____

Seen within Guidelines

Yes

No