CervicalCheck
AN CLÁR NÁISIÚNTA SCAGTHÁSTÁLA CEIRBHEACS
THE NATIONAL CERVICAL SCREENING PROGRAMME

Cervica

COMPLETE THE UNIQUE CLINIC CODE FOR YOUR STI/GUM CLINIC HERE (E.G. STI01000)

Detach the vial number label from the vial and place it here

Incomplete forms m
Please verify with th the form are correc
Once verified pleas abel from the sample via e form.

Please use every effort to provide the PPSN

A. Client's Details

Personal Public Service Number (Number / Letters)

CSP ID

Hospital Number (if applicable)

Date of Birth (Day / Month / Year)

Surname Use BLOCK CAPITAL

First Name

Middle Name

Surname at Birth

Mother's Maiden Name

To ensure accurate identification, please confirm details with the woman and complete this section in its entirety

Full Postal Address (The result letter will be sent to this address)

Eircode:

Contact Telephone No.

B. Consent

I have checked that all of
I have read and understood t
I consent to take part in CervicalCh

Client's Signature: _____

CervicalCheck does not accept third party consent for a client unless a family member or carer have specific legal authority to do so.

Ensure that consent is recorded here (signature, witnessed mark, verbal with note of doctor /nurse)

C. Deta s of Contract

THIS SECTION IS NOT FOR CLINICS

Medical Council Regis ation Number o contracted doctor:

OR

Clinic cod :
(CLIN COLP GYN PPCC STI or ONC)

Contracted Doctor or Clinic's Name:

Address:

Telephone No.

Complete name, address & phone number of THE CLINIC

D. Sampletaker's d

Complete Section D with the details of the HEALTH PROFESSIONAL WHO TOOK THE TEST

MCRN or NMBI

Sampletaker's name:

E. Cervical Screening Test Information

Date of Test (Day / Month / Year)

Identify the sample site

Sample site

☐ Cervix ☐ Vault (post total hysterectomy)

Where the cervix is present, the sampletaker must visualise the entire cervix and sample it correctly with 5 x 360° rotations of the broom/brush. Submission of the sample is confirmation that this has been done.

F. Relevant clinical details

Tick ONLY clinically appropriate boxes

LMP (Day / Month / Year)

- ☐ OCP/Hormones/HRT
- ☐ IUCD
- ☐ Post-menopausal
- ☐ Pre/Post Transplant
- ☐ Dialysis
- ☐ HIV Positive
- ☐ Post-coital bleeding
- ☐ Post-menopausal bleeding
- ☐ Sub-total Hysterectomy
- ☐ Total Hysterectomy

G. Screening and Treatment History

LABORATORY USE ONLY

Date Received in Laboratory (Day / Month / Year)

Accession number

1° 2°

TZ Cells Yes ☐ No ☐

Path

Management recommendation

Date Reported

Signature

CS/F/LAB-2 Rev 17