

Appendix 2: Forms

- A. Screening History Request Form
- B. Cytology Requisition Form
- C. Colposcopy Report Form
- D. Provider Number Request Form

Request for Cervical Screening Histories

1. Complete the contact information and the first 3 columns (name, PHIN and birth date).
2. Fax the form to CervixCheck at **204-779-5748**.
3. CervixCheck will fax back this form and the screening histories to the requesting clinic.
4. Call 204-788-8626 or toll free at 1-855-95-CHECK with any questions.

Clinic name: _____

Contact name: _____

Date: _____

Phone: _____

Fax: _____

NAME	PHIN	BIRTH DATE (YYYY/MM/DD)	SCREENING HISTORY FOR OFFICE USE ONLY

CERVICAL CYTOLOGY REQUEST FORM



Send specimen to:

- Dynacare Medical Laboratories**
 830 King Edward St, Ste #100, Winnipeg, MB R2H 0P4
 Ph: (204) 944-0757 Fax: (204) 957-1221
- Health Sciences Centre Cytology Laboratory**
 820 Sherbrook St (MS337), Winnipeg, MB R3A 1R9
 Ph: (204) 787-1352 Fax: (204) 787-1790
- Westman Laboratory**
 Unit I-150 McTavish Ave, E, Brandon, MB R7A 7H8
 Ph: (204) 578-4440 / 1-800-661-5458 Ext. 4467
 Fax: (204) 578-2819
- St. Boniface Hospital Cytology Laboratory**
 409 Taché, Winnipeg, MB R2H 2A6
 Ph: (204) 237-2504 Fax: (204) 235-3423
- Unicity Laboratory Services, Cytology Department**
 106-2200 McPhillips St, Winnipeg, MB R2V 3P4
 Ph: (204) 633-2806 Fax: (204) 632-9236

Accession #

Date received (dd/mmm/yyyy)

Specimen collection date (dd/mmm/yyyy)

PATIENT INFORMATION		
* Matching PHIN and first and last name required on vial (or slide in pencil)		
Last name	First name	
PHIN (or military, other prov/terr #)	MB Health #	
Date of birth (dd/mmm/yyyy)	Gender <input type="checkbox"/> F <input type="checkbox"/> M	3 rd party billing
Address		
City	Prov	Postal code

PATIENT HISTORY	
Last normal menses (dd/mmm/yyyy)	Last Pap test (dd/mmm/yyyy)
Previous abnormal Pap test (dd/mmm/yyyy)	
<input type="checkbox"/> Pregnant <input type="checkbox"/> Postpartum _____ (# weeks) <input type="checkbox"/> Menopausal <input type="checkbox"/> Postmenopausal	
PREVIOUS TREATMENT:	
<input type="checkbox"/> Colposcopy <input type="checkbox"/> Laser <input type="checkbox"/> Cryotherapy <input type="checkbox"/> LEEP <input type="checkbox"/> Knife cone <input type="checkbox"/> Irradiation <input type="checkbox"/> Wide local excision	
Date (dd/mmm/yyyy)	
HYSTERECTOMY:	Previous cancer
<input type="checkbox"/> Total <input type="checkbox"/> Subtotal	
PRESENT TREATMENT:	
Hormonal: <input type="checkbox"/> HRT <input type="checkbox"/> OCP <input type="checkbox"/> IUCD	
COMMENTS:	

SPECIMEN PREPARATION:
<input type="checkbox"/> Liquid based cytology <input type="checkbox"/> Conventional cytology
INSTRUMENT(S):
<input type="checkbox"/> Broom <input type="checkbox"/> Spatula <input type="checkbox"/> Cytobrush
SOURCE:
<input type="checkbox"/> Cervix <input type="checkbox"/> Vagina

PROVIDER INFORMATION				
Last name	First name			
CervixCheck/Provider #	Bill to (#)			
Send report to (street address)				
City/Town	Prov	Postal code		
Phone	Fax			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="padding: 5px;">Copy report to (name)</td> </tr> <tr> <td style="padding: 5px;">Address</td> </tr> </table>			Copy report to (name)	Address
Copy report to (name)				
Address				

DESIGNATION:		
<input type="checkbox"/> Physician	<input type="checkbox"/> Nurse practitioner	<input type="checkbox"/> Nurse
<input type="checkbox"/> Physician assistant	<input type="checkbox"/> Clinical assistant	<input type="checkbox"/> Midwife

Providers should identify themselves on the form as follows:

DESIGNATION	CERVIXCHECK/PROVIDER #:	BILL TO (#):
Clinical assistant	22### (CervixCheck provider #)	Physician or NP billing #
Midwife	M6### (Midwife provider #)	Midwife billing #
Nurse practitioner	Not applicable	Billing #
Nurse (RN, LPN)	N### (CervixCheck provider #)	Physician or NP billing #
Physician	Not applicable	Billing #
Physician assistant	72### (CervixCheck provider #)	Physician or NP billing #



COLPOSCOPY REPORT

PATIENT INFORMATION

Name: _____
 Date of birth: _____ yy / mo / dd
 PHIN: _____
 Address: _____
 Phone: _____
 Referring doctor: _____
 Fax: _____

Date: _____ yy / mo / dd

INITIAL VISIT FOLLOW-UP VISIT # _____

Last colposcopy date: _____ yy / mo / dd

PATIENT HISTORY

G _____ P _____ LNMP: _____

	No	Yes	DATE
Pregnancy (EDD)	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
HPV Vaccine	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Previous Cone	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Hysterectomy	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Previous Cryo	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Previous Laser	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Previous Leep	<input type="checkbox"/>	<input type="checkbox"/>	____/____/____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	
Sterilization	<input type="checkbox"/>	T/L <input type="checkbox"/> VAS. <input type="checkbox"/>	

Contraception: None OCP OTHER _____
 Allergies: _____
 Surg/Med Hx: _____

INITIAL REASON FOR COLPOSCOPY

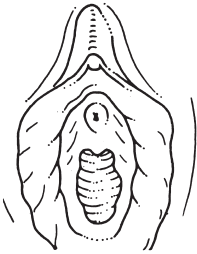
Cytology:
 Unsatisfactory
 blood inflammation
 ASC-US
 LSIL
 AGC
 ASC-H
 HSIL
 AIS
 Suspicious for Invasion
 Squamous Glandular

Other:
 Clinical Abn Cervix
 Vaginal Dysplasia
 Vulvar HPV
 Vulvar Dysplasia
 DES Exposure
 Other (specify) _____

FOLLOW-UP REASON FOR COLPOSCOPY

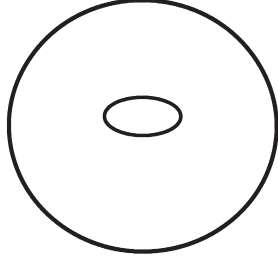
COLPOSCOPY EXAM

Satisfactory: yes no



Pelvic/Rectal Exam:
 Uterus
 Adnexa
 Vaginal Vault

COLPOSCOPIC IMPRESSION



Negative/Squam. Metaplsia
 Condyloma
 LSIL
 HSIL
 CIN 2 CIN 3
 AIS
 Invasion
 Squamous Glandular
 Radiation Changes
 Atrophic Changes

CYTOLOGY

YES NO

Negative
 Unsatisfactory
 blood inflammation
 ASC-US
 LSIL
 AGC
 ASC-H
 HSIL
 AIS
 Suspicious for Invasion
 squamous glandular

BIOPSY

YES NO

Negative
 Unsatisfactory
 HPV
 LSIL
 HSIL
 CIN 2 CIN 3
 SIL, Ungraded
 AIS
 SISCCA*
 Invasion
 squamous glandular

ENDOCERVICAL

YES NO

Negative
 Unsatisfactory
 LSIL
 HSIL
 CIN 2 CIN 3
 SIL, Ungraded
 AIS
 SISCCA*
 Invasion
 squamous glandular

TREATMENT TODAY

none
 Laser
 Cryotherapy
 LEEP excision
 LEEP conization
 Knife cone
 Wide local excision

Site of Treatment:
 Cervix Vagina

Anesthesia:
 None Paracervical
 Anesthetic Cervical

Post procedure bleeding:

RECOMMENDATIONS

Discharged
 Repeat colp in _____ mo
 Refer to oncology
 HPV vaccination

Treatment recommendations:
 Laser
 Cryotherapy
 LEEP excision
 LEEP conization
 Knife cone
 Wide local excision
 Hysterectomy

Planned treatment date:
 _____ yy / mo / dd

*Superficially invasive Squamous Cell Carcinoma

Comments:

Comments:

Signature: _____ MD

A copy of this report must be sent to CervixCheck within 30 days of the result of the colposcopy being known.
 All highlighted areas must be completed.

CervixCheck Provider Number Request Form

Nurses, clinical assistants (CA) and physician assistants (PA) should obtain a CervixCheck provider number at such point cervical cancer screening becomes part of their practice. The CervixCheck provider number identifies the specimen taker on the cytology requisition form, and links them to the cervical cancer screening test (i.e. Pap test) and any subsequent follow-up.

Nurses, CAs and PAs should identify themselves with their CervixCheck provider number on the cervical cytology request form in the “CervixCheck/Provider #” field. The billing number of the physician or nurse practitioner who may be overseeing these Pap tests can be captured in the “Bill to (#)” field.

Designation	CervixCheck/Provider #:	Bill to (#):
Clinical Assistant	22#### (CervixCheck provider #)	Physician or NP billing #
Nurse	N#### (CervixCheck provider #)	Physician or NP billing #
Physician Assistant	72#### (CervixCheck provider #)	Physician or NP billing #

The image shows a form titled "PROVIDER INFORMATION". The fields are as follows:

- Last name
- First name
- CervixCheck/Provider #** (circled in blue)
- Bill to (#)** (circled in blue)
- Send report to (street address)
- City/Town
- Prov
- Postal code
- Phone
- Fax
- Copy report to (name)
- Address

Important Information

- ✓ All nurses, CAs and PAs should ensure that their cytology lab captures their CervixCheck provider number with each Pap test report that is submitted to the CervixCheck registry.
- ✓ Registered nurses (extended practice), nurse practitioners and physicians do not need a CervixCheck provider number. Rather, they can record their billing number as assigned by Manitoba Health in the “Bill to (#)” field of the cytology requisition form.
- ✓ All clinicians shall refer to the CervixCheck Screening Guidelines at TellEveryWoman.ca to facilitate the required management of all cervical cytology follow-up in Manitoba.

CervixCheck Provider Number Request Form

To obtain a CervixCheck provider number, complete the fields on the reverse side of this page and fax or email to CervixCheck. Your CervixCheck provider number will be emailed to you.

First name	
Last name	
Professional designation (e.g. RN, PA, CA, LPN, etc.)	
Site name	
Site address	
City/town	
Postal code	
Phone	
Fax	
Email	

Contact CervixCheck:

- ✓ For screening histories of women in your care,
- ✓ For education and resources,
- ✓ For questions about screening and patient management, or
- ✓ To host a Pap clinic in your community.



Ph: 204-788-8626 | Toll free: 1-855-95-CHECK

Fax: 204-779-5748

CervixCheck@cancercare.mb.ca