Appendix 2: Forms

A. Screening History Request Form

B. Cytology Requisition Form

C. Colposcopy Report Form

D. Provider Number Request Form

CancerCare Manitoba
CervixCheck

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

GetCheckedManitoba.ca

CervixCheck, CancerCare Manitoba
P: 204-788-8626
Toll free: 1-855-95-CHECK
F: 204-779-5748

CERVICAL CYTOLOGY REQUEST FORM

CancerCare Manitoba
CervixCheck

Send specimen to:

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

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 #

☐ F ☐ M

Date of birth (dd/mmm/yyyy) Gender 3rd party billing

Address

City Prov Postal code

SPECIMEN PREPARATION:
☐ Liquid based cytology ☐ Conventional cytology

INSTRUMENT(S):
☐ Broom ☐ Spatula ☐ Cytobrush

SOURCE:
☐ Cervix ☐ Vagina

PATIENT HISTORY

Last normal menses (dd/mmm/yyyy) Last Pap test (dd/mmm/yyyy)

Previous abnormal Pap test (dd/mmm/yyyy)

☐ Pregnant ☐ Postpartum _____ (# weeks)
☐ Menopausal ☐ Postmenopausal

PREVIOUS TREATMENT:
☐ Colposcopy ☐ Laser ☐ Cryotherapy ☐ LEEP
☐ Knife cone ☐ Irradiation ☐ Wide local excision

Date (dd/mmm/yyyy)

HYSTERECTOMY:
☐ Total ☐ Subtotal

Previous cancer

PRESENT TREATMENT:
Hormonal: ☐ HRT ☐ OCP ☐ IUCD

COMMENTS:

PROVIDER INFORMATION

Last name First name

CervixCheck/Provider # Bill to (#)

Send report to (street address)

City/Town Prov Postal code

Phone Fax

Copy report to (name)

Address

DESIGNATION:
☐ Physician ☐ Nurse practitioner ☐ Nurse
☐ Physician assistant ☐ Clinical assistant ☐ 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 #

MAY 2016

COLPOSCOPY REPORT

PATIENT INFORMATION

Name: _____

Date of birth: _____
yy / mo / dd

PHIN: _____

Address: _____

Phone: _____

Referring doctor: _____

Fax: _____

PATIENT HISTORY

G _____ P _____ LNMP: _____

	No	Yes	DATE
Pregnancy (EDD)	☐	☐	_____/_____/_____
HPV Vaccine	☐	☐	_____/_____/_____
Previous Cone	☐	☐	_____/_____/_____
Hysterectomy	☐	☐	_____/_____/_____
Previous Cryo	☐	☐	_____/_____/_____
Previous Laser	☐	☐	_____/_____/_____
Previous Leep	☐	☐	_____/_____/_____
Smoking	☐	☐	

Sterilization ☐ T/L ☐ VAS. ☐

Contraception: None ☐ OCP ☐ OTHER ☐ _____

Allergies: _____

Surg/Med Hx: _____

Date: _____
yy / mo / dd

INITIAL VISIT ☐ FOLLOW-UP VISIT ☐ # _____

Last colposcopy date: _____
yy / mo / dd

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)

_____

_____

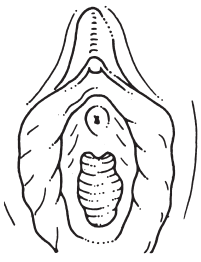
_____

_____

FOLLOW-UP REASON FOR COLPOSCOPY

COLPOSCOPY EXAM

Satisfactory: yes ☐ no ☐

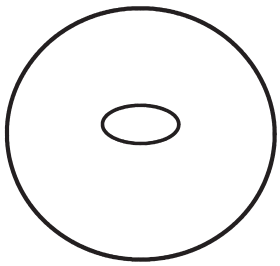


Pelvic/Rectal Exam:
Uterus

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

*Superficially invasive Squamous Cell Carcinoma

Comments:

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:

Comments:

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

Signature: _____ MD

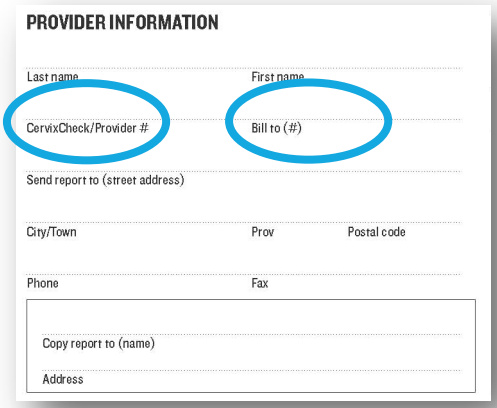
A copy of this report must be sent to CervixCheck within 30 days of the result of the colposcopy being known.
All highlighted areas must be completed.

CervixCheck Provider Number Request Form

Registered Nurses (RNs), Physician Assistants (PA), and Clinical Assistants (CL.A) 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.

RNs, PAs and CL.As should identify themselves with their CervixCheck Provider Number on the cervical cytology request form in the "CervixCheck/Provider #" field. *For specimens sent to Dynacare lab only:* A billing number must be submitted on the cervical cytology requisition form in the "Bill to (#)" field.

DESIGNATION	CERVIXCHECK/PROVIDER #:	BILL TO (#):
Clinical Assistant	22### (CervixCheck provider #)	Physician or NP billing #
Registered Nurse	N### (CervixCheck provider #)	Physician or NP billing #
Physician Assistant	72### (CervixCheck provider #)	Physician or NP billing #



Important Information

- ✓ All RNs, PAs and CL.As should ensure that their cytology lab captures their CervixCheck Provider Number with each Pap test that is ordered.
  - *For RNs, PAs and CL.As submitting specimens to Dynacare lab:* A billing number must be submitted on the cervical cytology requisition form in the "Bill to (#)" field. A copy of the lab report will be sent to you, but you will not be reflected as the specimen taker *in the CervixCheck registry*. CervixCheck is working with Dynacare for a solution to this.
- ✓ 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 GetCheckedManitoba.ca to facilitate the required management of all cervical cytology follow-up in Manitoba.

CancerCare Manitoba
CervixCheck

P: 204-788-8626 | Toll free: 1-855-95-CHECK
F: 204-779-5748
CervixCheck@cancercare.mb.ca
GetCheckedManitoba.ca

CervixCheck Provider Number Request Form

To obtain a CervixCheck Provider Number, complete the following fields and fax or email to CervixCheck. Your CervixCheck Provider Number will be emailed to you.

FIRST NAME	LAST NAME	DESIGNATION (RN, PA, CL.A)

CLINIC NAME

CLINIC ADDRESS	TOWN/CITY	POSTAL CODE

EMAIL	PHONE	FAX

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.

CancerCare Manitoba
CervixCheck

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