



## Colposcopy DNA Reporting Form

A woman DID NOT ATTEND her scheduled visit.

### 1. Woman's Detail

NHI No:

Date of Birth: / /

Last Name:

First Name(s):

Residential Address:

Date of booked appointment: / /

### 2. Intended Purpose of Visit

- First Specialist Appointment  
 Treatment  
 Follow-up

### 3. Practitioner/Clinic Details

Practitioner Name:  Health Facility Name:

### 4. Rescheduled Date

Rescheduled appointment date:

### 5. Follow-up within:

- |   |                                   |                                    |
|---|-----------------------------------|------------------------------------|
| <input type="checkbox"/> 7 days                       | <input type="checkbox"/> 6 months | <input type="checkbox"/> 12 months |
| <input type="checkbox"/> 1 month                      | <input type="checkbox"/> 7 months | <input type="checkbox"/> 18 months |
| <input type="checkbox"/> 4 months                     | <input type="checkbox"/> 9 months | <input type="checkbox"/> 36 months |
| <input type="checkbox"/> Discharge (referred back to) |                                   |                                    |
| <input type="text"/>                                  |                                   | Practitioner Name                  |
| <input type="text"/>                                  |                                   | Health Facility Name               |

Please send completed form to the NCSP Register Central Team at PO Box 5895, Lambton Quay, Wellington 6145. Fax 04 816 2422. Thank you.