



# Colposcopy **Visit** Reporting Form

Sections 1, 2, 3, 4 and 5 to be completed by administrative staff.

1. Woman's Details		2. Ethnicity
NHI No: _____ Date of Birth: / / _____		<p><i>(Please ask woman to complete)</i></p> <p>Which ethnic group do you belong to? Mark the space or spaces that apply to you.</p> <input type="checkbox"/> New Zealand European <input type="checkbox"/> Māori <input type="checkbox"/> Samoan <input type="checkbox"/> Cook Island Māori <input type="checkbox"/> Tongan <input type="checkbox"/> Niuean <input type="checkbox"/> Chinese <input type="checkbox"/> Indian <input type="checkbox"/> Other (please state): <i>(eg. Dutch, Japanese, Tokelauan)</i> _____ _____
Last Name: _____		
First Name(s): _____		
Residential Address: _____		
<b>3. Colposcopist/Clinic Details</b> Clinic No: _____ Colposcopist Reg. No: _____		
<b>4. Visit Date</b>	<b>5. Admission Type</b>	
/ /	<input type="checkbox"/> Outpatient <input type="checkbox"/> Day Stay <input type="checkbox"/> Inpatient	

6. Visit Details (Colposcopist please complete Sections 6.1, 6.2, 6.3, 6.4 and 6.5 by ticking relevant options)	
<b>6.1 Colposcopy performed:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>6.5 Actions during this visit</b> <i>(tick box and state reasons where relevant)</i> <input type="checkbox"/> Repeat smear <input type="checkbox"/> Review/Results discussed <input type="checkbox"/> Arranged treatment <input type="checkbox"/> Punch biopsy <input type="checkbox"/> Electro surgical excision of cervix <input type="checkbox"/> Laser ablation <input type="checkbox"/> Laser excision <input type="checkbox"/> Cold knife cone biopsy cervix <input type="checkbox"/> Subtotal hysterectomy <input type="checkbox"/> Total hysterectomy <input type="checkbox"/> HPV test <input type="checkbox"/> Other Notes _____
<b>6.2 Site: (tick ONE only)</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Vaginal	
<b>6.3 Transformation Zone Visible: (tick ONE only)</b> <input type="checkbox"/> No <input type="checkbox"/> Partially <input type="checkbox"/> Completely <input type="checkbox"/> NA	
<b>6.4 Colposcopic Appearance:</b> <input type="checkbox"/> Normal <input type="checkbox"/> NA <input type="checkbox"/> Abnormal <input type="checkbox"/> Inconclusive Predicted Abnormality Grade: <i>(tick ONE only)</i> <input type="checkbox"/> Low grade squamous <input type="checkbox"/> High grade squamous <input type="checkbox"/> Glandular <input type="checkbox"/> Micro-invasive cancer <input type="checkbox"/> Invasive cancer	

7. Recommended follow-up (Complete Sections 7.1 and 7.2 when results available)	
<b>7.1 Recommend follow-up with: (tick ONE only)</b> <input type="checkbox"/> Colposcopist <input type="checkbox"/> Oncology Services <input type="checkbox"/> Smartaker (referring practitioner)	
Practitioner Name _____ Health Facility _____	
<b>7.2 Follow-up within: (tick ONE only)</b> <input type="checkbox"/> 7 days <input type="checkbox"/> 2 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months <input type="checkbox"/> 18 months <input type="checkbox"/> 1 month <input type="checkbox"/> 4 months <input type="checkbox"/> 7 months <input type="checkbox"/> 12 months <input type="checkbox"/> 36 months	

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



# Colposcopy/Oncology **Referral** Reporting Form

ALWAYS complete Sections 1 and 2.

1. Woman's Detail	
NHI No:	Date of Birth:    /    /
Last Name:	
First Name(s):	
Residential Address:	
2. Referred By:	
Practitioner Name:	Health Facility:
3. Referred to:	
Health Facility:	

Complete Sections 4.1 and 4.2 for EACH REFERRAL received.

4. Referral Details
<b>4.1 Colposcopy/Oncology Booking Priority</b>
<input type="checkbox"/> Low Grade
<input type="checkbox"/> High Grade (includes HSIL and ASC-H)
<input type="checkbox"/> AGUS
<input type="checkbox"/> AIS
<input type="checkbox"/> ?Ca
<input type="checkbox"/> Abnormal Cervix – ?Ca
<input type="checkbox"/> Abnormal Cervix – normal smear history, including current smear
<input type="checkbox"/> Other:
Optional Comments:
<b>4.2 Date Colposcopy Referral Received</b>
/    /
<b>4.3 Method of Referral</b>
<input type="checkbox"/> Letter <input type="checkbox"/> Phone <input type="checkbox"/> Other

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