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Lab form for HPV/cytology and/or histology samples

Te Whatu Ora
Health New Zealand

Personal details		
NHI		
Family name		
Given names		
Preferred name		
Date of birth	dd mm yyyy	
Address		
Phone		
Email address		
Is the person eligible for publicly funded health services?		
<input type="radio"/> Yes	<input type="radio"/> No (Provide details of who should be billed below)	
Gender		
<input type="radio"/> Female	<input type="radio"/> Unknown	<input type="radio"/> Other gender
<input type="radio"/> Male	<input type="radio"/> Unspecified	
Ethnicity (Please ask the respondent to complete, can tick more than one)		
<input type="radio"/> New Zealand European	<input type="radio"/> Tongan	
<input type="radio"/> Māori	<input type="radio"/> Niuean	
<input type="radio"/> Samoan	<input type="radio"/> Chinese	
<input type="radio"/> Cook Island Māori	<input type="radio"/> Indian	
<input type="radio"/> Other, eg <i>Dutch, Japanese, Tokelauan</i> . Please state:		
<input type="radio"/> I do not know my ethnicity		
<input type="radio"/> I do not want to state my ethnicity		
Clinical presentation		
<input type="radio"/> No symptoms	<input type="radio"/> Postmenopausal Bleeding	
<input type="radio"/> Abnormal Bleeding	<input type="radio"/> Abnormal cervix	
<input type="radio"/> Postcoital Bleeding	<input type="radio"/> Other (enter below)	

History		
LMP dd mm yyyy	<input type="radio"/> Immune deficient	
<input type="radio"/> Total hysterectomy	<input type="radio"/> IUCD	
<input type="radio"/> Sub-total hysterectomy	<input type="radio"/> Breast feeding	
<input type="radio"/> Postmenopausal	<input type="radio"/> Genital infection	
<input type="radio"/> HRT	<input type="radio"/> Radiation Therapy	
<input type="radio"/> Pregnant, EDD dd mm yyyy	<input type="radio"/> Pessary	
<input type="radio"/> Using oral contraceptives	<input type="radio"/> Other (enter below)	
<input type="radio"/> Use of Depo Provera		
<input type="radio"/> Post-partum (< 3 months post-delivery)		
Previous results		
Previous abnormal screening tests?		
<input type="radio"/> Yes	<input type="radio"/> No	<input type="radio"/> Unknown
Test site		
<input type="radio"/> Cervical	<input type="radio"/> Endocervical	<input type="radio"/> Vaginal / vault
Specimen type		
<input type="radio"/> Vaginal Swab	<input type="radio"/> LBC	
Test(s) requested		
<input type="radio"/> Swab – HPV		
<input type="radio"/> LBC – HPV and cytology if required		
<input type="radio"/> LBC – HPV and cytology (co-test)		
<input type="radio"/> LBC – cytology only		
Histology site		
Histology specimen type		
<input type="radio"/> Punch biopsy	<input type="radio"/> Total hysterectomy	
<input type="radio"/> LLETZ	<input type="radio"/> Sub-total hysterectomy	
<input type="radio"/> Cone biopsy	<input type="radio"/> Other (enter below)	

Urgent test results	
For urgent results provide contact name and phone number	
Name	
Phone	
Laboratory identifiers (Lab to complete)	
Date received by Lab	dd mm yyyy
Requestor details	
Practitioner name	
Health Practitioner Indicator (HPI)	
Health Facility Name	
Health Facility Number (HPI)	
Additional copy of results to	
Date taken	dd mm yyyy
Signature of Practitioner / Sample taker	
Additional comments	
For private specialist colposcopists and oncologists only	
Is this a screening sample? <input type="radio"/> Yes <input type="radio"/> No	