

# Lab form for HPV/cytology and/or histology samples

Personal details	
NHI	
Family name	
Given names	
Preferred name	
Date of birth	dd mm yyyy
Address	
Phone	
Email address	

Personal details continued		
Is this 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	

Clinical presentation	
<input type="radio"/> No symptoms	<input type="radio"/> Postmenopausal bleeding
<input type="radio"/> Abnormal bleeding	<input type="radio"/> Other (enter below)
<input type="radio"/> Postcoital bleeding	
<input type="radio"/> Abnormal cervix	

Immune status	
Immune deficient?	<input type="radio"/> Yes <input type="radio"/> No

History	
LMP dd mm yyyy	<input type="radio"/> IUCD
<input type="radio"/> Total hysterectomy	<input type="radio"/> Pregnant
<input type="radio"/> Sub-total hysterectomy	<input type="radio"/> Post-partum (<3 months post-delivery)
<input type="radio"/> Postmenopausal	<input type="radio"/> Breast feeding
<input type="radio"/> HRT	<input type="radio"/> Genital infection
<input type="radio"/> Using oral contraceptives - combined	<input type="radio"/> Radiation therapy
<input type="radio"/> Using oral contraceptives - progesterone only	<input type="radio"/> Pessary
<input type="radio"/> Using Depo Provera	<input type="radio"/> Other (enter below)

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	

For gynaecologists, colposcopists and oncologists only	
Sample taken during a colposcopy?	<input type="radio"/> Yes <input type="radio"/> No

Histology site	

Histology specimen type	
<input type="radio"/> Punch biopsy	<input type="radio"/> Sub-total hysterectomy
<input type="radio"/> LLETZ	<input type="radio"/> Other (enter below)
<input type="radio"/> Cone biopsy	
<input type="radio"/> Total hysterectomy	

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	
Name of clinician responsible for test results	
Clinician Health Provider Index (HPI)	
Health Facility Name	
Health Facility Health Provider Index (HPI)	
Additional copy of results to	
Date taken	dd mm yyyy

Colposcopic impression and other clinical comments	