

Referral Form

**Evaluation of Abnormal Pap and/or Colposcopy**  
**General Obstetrics & Gynecology**

To schedule your patient, please include any pertinent records including Pap smear results, pathology reports, or relevant office notes unless available in CIS.

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ \*Age: \_\_\_\_\_

\*For women 20 years or younger: if Pap is ASCUS or LSIL, repeat Pap in 12 months (even if HPV positive); if that Pap (#2) is ASCUS or LSIL, repeat again in 12 months; if repeat (#3) is still abnormal, refer for colposcopy.

**Current Pap Smear:**

Date of Pap Smear: \_\_\_\_\_

- Normal Pap with persistent High Risk HPV positive
- ASCUS with positive High Risk HPV
- LSIL

- HSIL
- AGUS
- Other: \_\_\_\_\_

Prior Treatment for Abnormal Pap?  Yes  No

If yes, please describe: \_\_\_\_\_

Is patient pregnant?  Yes  No

If yes, please provide EDD: \_\_\_\_\_

**Reason for Request (please check only one):**

- Consultation & Colposcopy: Colposcopy and other evaluative testing will be performed, if indicated. We will follow up with the patient and formulate and execute treatment plans. The patient will be returned to you for decisions regarding all other aspects of her care, including follow-up pap smears and other gynecological care.
- Other (describe): \_\_\_\_\_

Preferred Day of Week: \_\_\_\_\_ AM / PM

Please note: we strive to meet these requests, but may not always be able to do so.

Referring Provider: \_\_\_\_\_ Office # \_\_\_\_\_

Contact Person: \_\_\_\_\_ Fax #: \_\_\_\_\_

Address: \_\_\_\_\_

May we send notes to you via Hitchcock email?  Yes  No

Is the patient aware of this referral so she may be contacted by our office?  Yes  No

Would your office like notification of this appointment?  Yes  No