Appendix 2: Forms

A. Screening History Request Form

B. Cytology Requisition Form

C. Colposcopy Report Form

D. Provider Number Request Form

Request for Cervical Cancer Screening Histories

1. Enter your contact information.
2. Complete the first 3 columns (name, PHIN and birth date).
3. Fax the completed form to CervixCheck at **204-779-5748**.
4. CervixCheck will fax back this form and the screening histories to the requesting clinic.

***Clinic name:** _____

***Contact name:** _____ ***Date:** _____

***Phone number:** _____ ***Fax number:** _____

***Required fields.**

*NAME	*PHIN	*BIRTH DATE (YYYY/MM/DD)	SCREENING HISTORY FOR OFFICE USE ONLY

X-FORM-SCREENING-HISTORY 2021.07

CancerCare Manitoba
ActionCancerManitoba
BreastCheck CervixCheck ColonCheck

1-855-95-CHECK | Fax: 204-779-5748
screening@cancercare.mb.ca
cancercare.mb.ca/screening

CERVICAL CYTOLOGY REQUEST FORM

CancerCare Manitoba
ActionCancerManitoba
BreastCheck CervixCheck ColonCheck

Send specimen to:

☐ **Health Sciences Centre Cytology Laboratory**
820 Sherbrook St (MS337), Winnipeg, MB R3A 1R9
P: 204-787-1352 F: 204-787-1790

☐ **Westman Laboratory**
Unit 1-150 McTavish Ave, E, Brandon, MB R7A 7H8
P: 204-578-4440 / 1-800-661-5458 Ext. 4467
F: 204-578-2819

☐ **St. Boniface Hospital Cytology Laboratory**
409 Taché, Winnipeg, MB R2H 2A6
P: 204-237-2504 F: 204-235-3423

☐ **Dynacare**
830 King Edward St, Ste #100, Winnipeg, MB R2H 0P4
P: 204-944-0757 F: 204-957-1221

Accession # **Date received (dd/mmm/yyyy)** **Specimen collection date (dd/mmm/yyyy)**

PATIENT INFORMATION

* Matching PHIN and first and last name required on vial

Last name First name

PHIN (or military, other prov/terr #) MB Health #

☐ F ☐ M

Date of birth (dd/mmm/yyyy) Gender 3rd party billing

Address

City Prov Postal code

SPECIMEN PREPARATION:
☐ Liquid based cytology ☐ Conventional cytology

INSTRUMENT(S):
☐ Broom ☐ Spatula ☐ Cytobrush

SOURCE:
☐ Cervix ☐ Vagina

PATIENT HISTORY

Last normal menses (dd/mmm/yyyy) Last Pap test (dd/mmm/yyyy)

Previous abnormal Pap test (dd/mmm/yyyy)

☐ Pregnant ☐ Postpartum _____ (# weeks)
☐ Menopausal ☐ Postmenopausal

PREVIOUS TREATMENT:
☐ Colposcopy ☐ Laser ☐ Cryotherapy ☐ LEEP
☐ Knife cone ☐ Irradiation ☐ Wide local excision

Date (dd/mmm/yyyy)

HYSTERECTOMY:
☐ Total ☐ Subtotal

Previous cancer

PRESENT TREATMENT:
Hormonal: ☐ HRT ☐ OCP ☐ IUCD

COMMENTS:

SPECIMEN COLLECTOR INFORMATION

Last name First name

CervixCheck/Provider # Bill to (#)

Send report to (street address)

City/Town Prov Postal code

Phone Fax

Copy report to (name)

Address

DESIGNATION:
☐ Physician ☐ Nurse practitioner ☐ Nurse
☐ Physician assistant ☐ Clinical assistant ☐ Midwife

Specimen collector should identify themselves on the form as follows:

DESIGNATION	CERVIXCHECK/PROVIDER #:	BILL TO (#):
Clinical assistant	22### (CervixCheck provider #)	Physician or NP billing #
Midwife	M6### (Midwife provider #)	Midwife billing #
RN(NP)	Not applicable	Billing #
RN, RN(AP), RPN	N### (CervixCheck provider #)	Physician or NP billing #
Physician	Not applicable	Billing #
Physician assistant	72### (CervixCheck provider #)	Physician or NP billing #

COLPOSCOPY REPORT

ALL HIGHLIGHTED AREAS MUST BE COMPLETED

Colposcopist name: _____

Clinic name: _____

Clinic address: _____

Phone: _____ **Fax:** _____

PATIENT INFORMATION

Name: _____

Date of birth: _____ PHIN: _____
yyyy/mm/dd

Address: _____

Phone: _____

Referring doctor: _____

Fax: _____

PATIENT HISTORY

G_____ P_____ LNMP: _____

	No	Yes	Date yyyy/mm/dd
Pregnancy (EDD)	☐	☐	_____/_____/_____
HPV vaccine	☐	☐	_____/_____/_____
Previous cone	☐	☐	_____/_____/_____
Hysterectomy	☐	☐	_____/_____/_____
Previous cryo	☐	☐	_____/_____/_____
Previous laser	☐	☐	_____/_____/_____
Previous LEEP	☐	☐	_____/_____/_____
Smoking	☐	☐	

Sterilization ☐ T/L ☐ VAS. ☐

Contraception None ☐ OCP ☐ OTHER ☐ _____

Allergies: _____

Surg/Med Hx: _____

Date of colposcopy examination _____
yyyy/mm/dd

☐ INITIAL VISIT ☐ FOLLOW-UP VISIT #____

Last colposcopy date: _____

INITIAL REASON FOR COLPOSCOPY

Abnormal cervical cancer screening test:

- ☐ Unsatisfactory
  - ☐ blood ☐ inflammation
- ☐ ASCUS (Persistent)
- ☐ ASCUS/HPV+
  - ☐ 16 ☐ 18 ☐ Other
- ☐ LSIL (Persistent)
- ☐ LSIL/HPV+
  - ☐ 16 ☐ 18 ☐ Other
- ☐ AGC
- ☐ ASC-H
- ☐ HSIL
- ☐ AIS
- ☐ Suspicious for invasion:
  - ☐ squamous ☐ glandular ☐ unknown

Other:

- ☐ Clinical Abnormal Cervix
- ☐ Vaginal Dysplasia
- ☐ Vulvar HPV
- ☐ Vulvar Dysplasia
- ☐ DES Exposure
- ☐ Other (specify)

_____

_____

_____

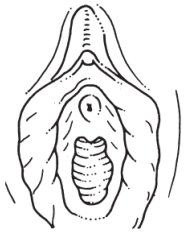
_____

_____

FOLLOW-UP REASON FOR COLPOSCOPY

COLPOSCOPY EXAM

☐ Satisfactory (Type 1 or 2 TZ) ☐ Unsatisfactory (Type 3 TZ)



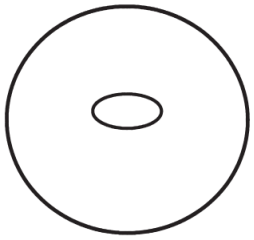
Pelvic/rectal exam:

Uterus

Adnexa

Vaginal vault

COLPOSCOPIC IMPRESSION



- ☐ Negative/Squamous metaplasia
- ☐ Condyloma
- ☐ LSIL
- ☐ HSIL
  - ☐ CIN 2 ☐ CIN 3
- ☐ AIS
- ☐ Invasion
  - ☐ squamous ☐ glandular
- ☐ Radiation changes
- ☐ Atrophic changes

CYTOLOGY

☐ YES ☐ NO

- ☐ Negative
- ☐ Unsatisfactory
  - ☐ blood ☐ inflammation
- ☐ ASCUS
- ☐ LSIL
- ☐ AGC
- ☐ ASC-H
- ☐ HSIL
- ☐ AIS
- ☐ Suspicious for invasion
  - ☐ squamous ☐ glandular

BIOPSY

☐ YES ☐ NO

- ☐ Negative
- ☐ Unsatisfactory
- ☐ LSIL
- ☐ HSIL
  - ☐ CIN 2 ☐ CIN 3
- ☐ SIL, ungraded
- ☐ AIS
- ☐ SISCCA*
- ☐ Invasion
  - ☐ squamous ☐ glandular

ENDOCERVICAL

☐ YES ☐ NO

- ☐ Negative
- ☐ Unsatisfactory
- ☐ LSIL
- ☐ HSIL
  - ☐ CIN 2 ☐ CIN 3
- ☐ SIL, ungraded
- ☐ AIS
- ☐ SISCCA*
- ☐ Invasion
  - ☐ squamous ☐ glandular

Comments:

TREATMENT TODAY

- ☐ None
- ☐ Laser
- ☐ Cryotherapy
- ☐ LEEP excision
- ☐ LEEP conization
- ☐ Knife cone
- ☐ Wide local excision

Site of Treatment:

☐ Cervix ☐ Vagina

Anesthesia:

☐ None ☐ Paracervical

☐ Anesthetic ☐ Cervical

Post procedure bleeding:

Comments:

RECOMMENDATIONS

- ☐ Discharged
  - ☐ Pap every 3 years
  - ☐ Pap every 1 year
- ☐ Repeat colp in _____ months
- ☐ Refer to oncology
- ☐ HPV vaccination

Treatment recommendations

- ☐ Laser
- ☐ Cryotherapy
- ☐ LEEP excision
- ☐ LEEP conization
- ☐ Knife cone
- ☐ Wide local excision
- ☐ Hysterectomy

Planned treatment date:

_____
yyyy/mm/dd

*Superficially invasive squamous cell carcinoma

Signature:_____**MD**

A copy of this report must be sent to CervixCheck within 30 days of the result of the colposcopy being known.

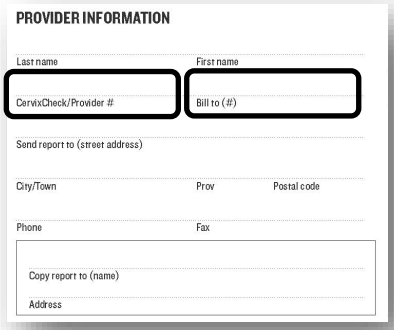
09/2021

CervixCheck Provider Number Request Form

Registered Nurses (RNs), Physician Assistants (PA), and Clinical Assistants (CL.A) should obtain a CervixCheck Provider Number at such point cervical cancer screening becomes part of their practice. The CervixCheck Provider Number identifies the specimen taker on the cytology requisition form, and links them to the cervical cancer screening test (i.e. Pap test) and any subsequent follow-up.

RNs, PAs and CL.As should identify themselves with their CervixCheck Provider Number on the cervical cytology request form in the "CervixCheck/Provider #" field. *For specimens sent to Dynacare lab only:* A billing number must be submitted on the cervical cytology requisition form in the "Bill to (#)" field.

	Record in the *CervixCheck/ Provider #* field	**Record in *Bill To (#)* field**
Clinical Assistant	22###	Physician or NP billing #
Registered Nurse	N###	Physician or NP billing #
Physician Assistant	72###	Physician or NP billing #



Important Information

- ✓ All RNs, PAs and CL.As should ensure that their cytology lab captures their CervixCheck Provider Number with each Pap test that is ordered.
    - *For RNs, PAs and CL.As submitting specimens to Dynacare lab:* A billing number must be submitted on the cervical cytology requisition form in the "Bill to (#)" field. A copy of the lab report will be sent to you, but you will not be reflected as the specimen taker *in the CervixCheck registry*. CervixCheck is working with Dynacare for a solution to this.
- ✓ Registered nurses (extended practice), nurse practitioners and physicians do not need a CervixCheck Provider Number. Rather, they can record their billing number as assigned by Manitoba Health in the "Bill to (#)" field of the cytology requisition form.
- ✓ All clinicians shall refer to the CervixCheck Screening Guidelines at https://www.cancercare.mb.ca/screening/hcp to facilitate the required management of all cervical cytology follow-up in Manitoba.

CervixCheck Provider Number Request Form

To obtain a CervixCheck Provider Number, complete the following fields and fax or email to CervixCheck. Your CervixCheck Provider Number will be emailed to you. If you are registered for the CervixCheck Competency Training, you do not need to complete this form. A number will be provided to you on your certificate of participation post-training.

FIRST NAME	LAST NAME	DESIGNATION (RN, PA, CA)
CLINIC NAME		
CLINIC ADDRESS	TOWN/CITY	POSTAL CODE
EMAIL	PHONE	FAX

CONTACT CERVIXCHECK:

- ✓ For screening histories of patients in your care,
- ✓ For education and resources,
- ✓ For questions about screening and patient management, or
- ✓ To host a Pap clinic in your community.