COLPOSCOPY REPORT

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

Colposcopist name: _____

Clinic name: _____

Clinic address: _____

Phone: _____ **Fax:** _____

PATIENT INFORMATION

Name: _____

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

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: _____ (yyyy/mm/dd)

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)

_____

_____

_____

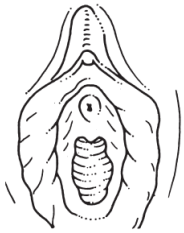
_____

_____

FOLLOW-UP REASON FOR COLPOSCOPY

COLPOSCOPY EXAM

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



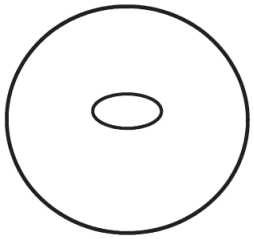
Pelvic/rectal exam:

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
- ☐ 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

TREATMENT TODAY

- ☐ Laser
- ☐ Cryotherapy
- ☐ LEEP/LLETZ
- ☐ Wide local excision
- ☐ OTHER: _____

TREATMENT SITE

☐ Cervix ☐ Vagina

ANESTHESIA

- ☐ Anesthetic
- ☐ Paracervical
- ☐ Cervical

RECOMMENDATIONS

- ☐ Discharged
  - ☐ Pap every 3 years
  - ☐ Pap every 1 year
- ☐ Repeat colp. ____months
- ☐ Refer to oncology
- ☐ HPV vaccination

TREATMENT

- ☐ Laser
- ☐ Cryotherapy
- ☐ LEEP /LLETZ
- ☐ Wide local excision
- ☐ Hysterectomy

Planned treatment date:

HPV TEST

☐ YES ☐ NO

- ☐ Negative
- ☐ Positive
  - ☐16 ☐18 ☐ Other

Comments:

*Superficially invasive squamous cell carcinoma

12/31/2024

Signature: _____ **MD**