DO NOT PLACE LABEL ABOVE LINE

BC CANCER CERVIX SCREENING Provincial Health Services Authority

TREATMENT FORM

AFFIX CLIENT LABEL HERE

FAX COPY TO CERVIX SCREENING PROGRAM: 1 (604) 297-9327

EXAM DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F|M|X)

FACILITY | AMENDED DATE (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD)

COLPOSCOPIST (MSC) | COLPOSCOPIST LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

REFERRING PROVIDER (MSC) | REFERRING PROVIDER LAST, FIRST
(If different from Primary Provider above)

1. INDICATION

- ☐ Treatment of:
  - ☐ CIN 2/3
  - ☐ AIS
  - ☐ VAIN 2/3
  - ☐ Malignant
- ☐ Diagnosis
  - ☐ CIN 1 on bx
  - ☐ Bx not possible
  - ☐ Cyto/histo discrepancy 2+ levels
- ☐ Other: _____

2. PATIENT DOCUMENTATION

Patient identity confirmed
☐ Yes ☐ No

Verbal or written consent
☐ Yes ☐ No

Allergies Documented
☐ Yes ☐ No

Pregnancy Test
☐ Pos ☐ Neg ☐ Not done

COMMENTS

3. LOCATION OF PROCEDURE

- ☐ Colposcopy Clinic
- ☐ Operating Room
  - ☐ Patient related (anxiety or anatomy)
  - ☐ No access to clinic setting

4. PROCEDURE

Anatomical Site
☐ Cervix ☐ Vagina

Size of Lesion
☐ Not visible ☐ <1cm ☐ 1-2cm ☐ >2cm

Anesthetic
☐ Local ☐ Sedation ☐ General

Other Medications
_____

5. PROCEDURE TYPE

- ☐ **LEEP** Loop Size: _____ Voltage: _____ Blend: _____ Cut: _____
  # of Fragments ☐ 1 ☐ 2 ☐ >2 Top Hat Excision ☐ Yes ☐ No
- ☐ **Laser** ☐ Safety check completed Power: _____ Mode: _____
- ☐ **Cone**
- ☐ **Cryotherapy**
  Freeze technique _____
- ☐ **Wide Local Excision**
  Excision size/description

6. OTHER PROCEDURES

☐ ECC ☐ Cervical Bx
☐ Endometrial Bx ☐ Vaginal Bx
☐ Other: _____

7. UNPLANNED EVENTS

☐ None
☐ Pain ☐ Vasovagal
☐ Bleeding ☐ Flush
☐ Other: _____

COMMENTS

8. PATHOLOGY RESULTS

☐ Negative for Dysplasia
☐ HPV/Condyloma ☐ Benign Atypia
☐ CIN1 ☐ CIN2 ☐ CIN3 ☐ HSIL NOS ☐ AIS
☐ Microinvasive SCC ☐ Malignant SCC
☐ Adenocarcinoma ☐ VAIN 1 ☐ VAIN 2/3
☐ Other: _____

Margin
☐ Negative ☐ Positive ☐ Indeterminate

Comments

9. RECOMMENDATIONS (Complete only 9a or 9b) Date (YYYYMMDD)

9a. Return to Colposcopy Clinic

Colposcopy in: Booked: ☐ Yes ☐ No
☐ 6 Months ☐ 12 Months ☐ _____ Months

Treatment within: Booked: ☐ Yes ☐ No
☐ 2 Months ☐ _____ Months
Site: ☐ Cervix ☐ Vagina
Type: ☐ LEEP ☐ Laser ☐ Other: _____

9b. Other Recommendation

☐ Patient Referred to BC Cancer

☐ Gynecological Consult (Colposcopist Arranging)
☐ Hysterectomy Discussion
☐ Other: _____

HPV Vaccine
☐ HPV Vaccine Recommended
☐ HPV Vaccine Rx Provided

Attention Provider
☐ Inform Patient of Result
☐ Patient Aware of Result

Colposcopist Signature

INFORMATION ON THIS FORM IS CONFIDENTIAL
IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604)708-2114

Please press firmly to ensure that all 3 copies of this form are legible
Fax copy to Cervix Screening Program: 1 (604) 297-9327

Patient Identifiers: A label can be used if legible and affixed in the upper right corner, otherwise complete all fields. If a legible hospital label is used you do not need to enter the patient name, date of birth, or PHN.
Primary Provider: Indicate the patients primary care provider, this is often the same as the referring provider.
Referring Provider: Indicate the provider that referred the patient for Colposcopy.

1. Indication: Choose only one reason for treatment.
Treatment of: The patient has a diagnosis of HSIL+ and is presenting for treatment. More than one result can be chosen.
Diagnosis: The patient does not have a diagnosis of HSIL+ on biopsy and requires a diagnostic excisional procedure. Only one reason for completing a diagnostic procedure can be chosen.
Other: Only choose if reasons for treatment are not otherwise listed in this section, and describe indication.

2. Patient Documentation: Ensure that all yes/no boxes are completed. Choose whether a pregnancy test was done or not. If done, choose the result (pos/neg). *Enter any additional comments in the space provided for your records.*

3. Procedure
Anatomical Site: Choose all sites that are being treated.
Size of Lesion: Choose size of lesion. Only one can be chosen.
Anesthetic: Choose type of anesthetic. More than one can be chosen.
Other Medications: *List any other medications that were given at the time of the procedure. If none, leave blank.*

4. Location of Procedure: Choose location of procedure. If the procedure was done in an operating room you must choose the reason for using the OR - either “patient related (anxiety or anatomy)” or “no access to clinic setting”.

5. Procedure Type: Choose one of the following procedures being completed. More than one procedure can be chosen.
LEEP: Document the loop size, cautery settings, number of fragments and if a top hat excision was done or not.
Laser: Document if the safety check was completed and document the power and mode used.
Cone:
Cryotherapy: Cryotherapy should not be used to treat HSIL+; indicate the freeze technique.
Wide Local Excision: Describe the size and technique of the excision.

6. Other Procedures: Choose any additional procedures. If a procedure is not listed choose “other” and describe in the space provided.

7. Unplanned Events: Use to document events which are more severe than what is normally expected. If there were no unplanned events, choose “none”. If the unplanned event is not listed, choose “other” and describe in the space provided.

8. Pathology Results: Choose results (most severe) after the pathology results are received. More than one result can be chosen. If the result is not listed choose “other” and indicate in the space provided.
Margins: Choose “negative”, “positive” or “indeterminate”. Only one margin status can be chosen.
Comments: *Document any additional comments in the space provided for your records.*

7. Recommendations: The patient must have one of the following recommendations: repeat colposcopy, treatment, referred to BC Cancer, gynecological consult (colposcopist arranging) or no further follow-up.
HPV Vaccine Recommended/Prescribed: If the HPV vaccine is recommended or was prescribed choose “yes”.
Return to Colposcopy Clinic: Choose whether it is for a repeat colposcopy or treatment.
Repeat Colposcopy: Choose repeat interval of 1, 2, 4, 6 or 12 months and if the procedure has been booked (“Yes”) or not booked (“No”). Colposcopy clinics will only be notified that the patient requires a visit if “No” is chosen.
Treatment: Choose interval of 1 or 2 months and if the procedure has been “booked” (“Yes”) or not booked (“No”). Colposcopy clinics will only be notified that the patient requires a visit if “No” is chosen.
For the Following Three Choices: No recalls will be sent for patients until a subsequent Pap result, Colposcopy Form or Treatment Form is submitted with recall recommendations.

- **Patient Referred to BC Cancer:** Choose if the patient has a diagnosis of cancer that requires gynecologic oncology.
- **Gynecological Consult:** Choose if you have referred the patient for gynecological consult and choose either “hysterectomy discussion” or “other” and indicate reason in the space provided.
- **No Further Screening or Colposcopy Required:** This generally should not be selected for patients immediately post treatment.
- **Attention Referring Physician:** Choose if you have informed the patient of their result or if the primary care provider is expected to inform the patient of their results.