COLPOSCOPY REPORT

ALL HIGHLIGHTED AREAS MUST BE COMPLETED

Colposcopist name: ______________________

Clinic name: ______________________

Clinic address: ______________________

Phone: ______________ **Fax:** ______________

PATIENT INFORMATION

Name: ______________________

Date of birth: ____________ (yyyy/mm/dd) PHIN: ______________

Address: ______________________

Phone: ______________________

Referring doctor: ______________________

Fax: ______________________

Date of colposcopy examination ____________ (yyyy/mm/dd)

☐ INITIAL VISIT ☐ FOLLOW-UP VISIT # ____

Last colposcopy date: ____________

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: ______________________

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)

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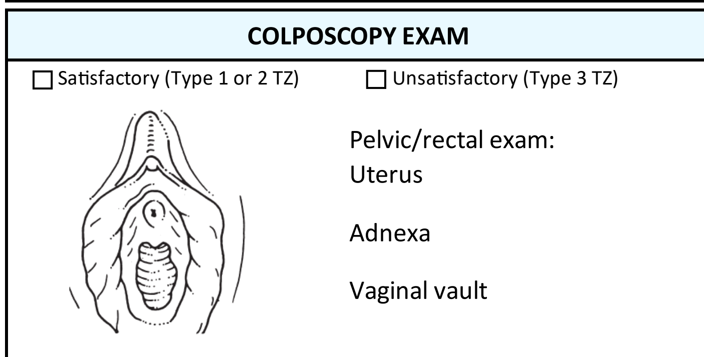
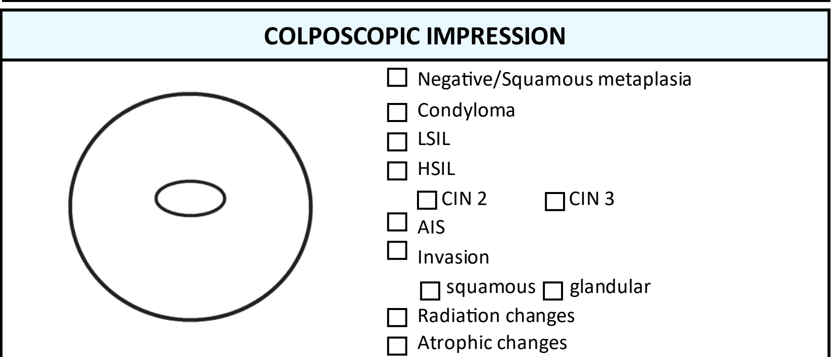
FOLLOW-UP REASON FOR COLPOSCOPY

COLPOSCOPY EXAM

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



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