RESOURCE FROM:

Cervical cancer screening and treatment in low-resource settings:
PRACTICAL EXPERIENCE FROM PATH

PUBLICATION TITLE

Referral Form

PUBLISHER

Ministry of Health, Uganda; PATH

PUBLICATION DATE

2010

This document is available online at:
www.rho.org/HPV-screening-treatment.htm

REFERRAL FORM

With Support from;

*Health Facility:*____________________ *District:*________________ *Record No.*________

Date:________________

Client's Name:________________________________ Age:____________

Registration No.____________________ ID Number:____________________

Address (District)____________________ SubCounty/Village: ____________________

Telephone: ________________________

Date screened (dd/mm/yyyy)________________ Name of Facility:________________

Pelvic exam ○ Normal ○ Abnormal (please specify below in Refer Block)

Suspect cancer ○ No ○ Suspect cancer (please specify below in Refer Block)

Complete SCJ ○ Complete ○ Incomplete visualization, do, on ☐☐-☐☐-☐☐

(please follow and specify below)

Cervical mapping (map the cervix after application of acetic acid for 1 min. In diagram on the right hand)

Symbols:
- Outline of SCJ
- Acetowhite lesion
- Cervical Os
- Suspect Cancer area

VIA result ○ Negative ○ Positive

Cryotherapy ○ Refused by client ○ Immediately ○ Postpone

○ Not eligible (specify reason below) had cryotherapy on ☐☐-☐☐-☐☐

Refer

To facility name____

Reason for refer

○ PID ○ Polyp ○ Myoma ○ Adnexal mass Other gyne problems

○ Suspect Cancer ○ Large lesion Other non-gyne problems________________

Provider's name____

Pap's smear report

Date received (dd/mm/yy) ☐☐-☐☐-☐☐

Result Summary ○ Not adequate speceimen

○ No malignancy/information ○ ASCUS/AGUS ○ Low SIL ○ High SIL ○ Malignancy

FEEDBACK FORM; *To be returned to the Referring Centre;*____________________

Date:________________

Client's Name:________________________________ Age:____________

Registration No.____________________ ID Number:____________________

Address (District)____________________ Sub County/Village:____________________

Telephone:____________________ Arrival Date:____________________

Diagnosis____

Treatment Given:____

Name & Title of Provider:____________________ Health Facility:____________________