

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



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: _____

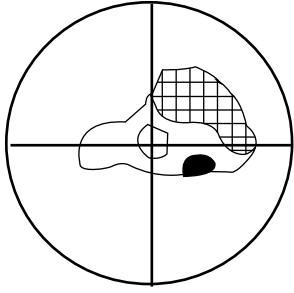
Pelvic exam Normal Abnormal (please specify below in Refer Block)

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)




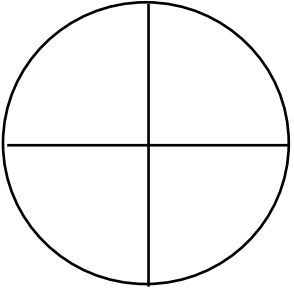
Symbols:

 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: _____