Lab form for HPV/cytology and/or histology samples

Te Whatu Ora
Health New Zealand

Personal details

NHI	
Family name	
Given names	
Preferred name	
Date of birth	dd mm yyyy
Address	
Phone	
Email address	

Is the person eligible for publicly funded health services?

- ◯ Yes
- ◯ No (Provide details of who should be billed below)

Gender

- ◯ Female
- ◯ Male
- ◯ Unknown
- ◯ Unspecified
- ◯ Other gender

Ethnicity (Please ask the respondent to complete, can tick more than one)

- ◯ New Zealand European
- ◯ Māori
- ◯ Samoan
- ◯ Cook Island Māori
- ◯ Tongan
- ◯ Niuean
- ◯ Chinese
- ◯ Indian
- ◯ Other, eg *Dutch, Japanese, Tokelauan.* Please state:
- ◯ I do not know my ethnicity
- ◯ I do not want to state my ethnicity

Clinical presentation

- ◯ No symptoms
- ◯ Abnormal Bleeding
- ◯ Postcoital Bleeding
- ◯ Postmenopausal Bleeding
- ◯ Abnormal cervix
- ◯ Other (enter below)

History

LMP dd mm yyyy

- ◯ Total hysterectomy
- ◯ Sub-total hysterectomy
- ◯ Postmenopausal
- ◯ HRT
- ◯ Pregnant, EDD dd mm yyyy
- ◯ Using oral contraceptives
- ◯ Use of Depo Provera
- ◯ Post-partum (< 3 months post-delivery)
- ◯ Immune deficient
- ◯ IUCD
- ◯ Breast feeding
- ◯ Genital infection
- ◯ Radiation Therapy
- ◯ Pessary
- ◯ Other (enter below)

Previous results

Previous abnormal screening tests?

- ◯ Yes
- ◯ No
- ◯ Unknown

Test site

- ◯ Cervical
- ◯ Endocervical
- ◯ Vaginal / vault

Specimen type

- ◯ Vaginal Swab
- ◯ LBC

Test(s) requested

- ◯ Swab – HPV
- ◯ LBC – HPV and cytology if required
- ◯ LBC – HPV and cytology (co-test)
- ◯ LBC – cytology only

Histology site

Histology specimen type

- ◯ Punch biopsy
- ◯ LLETZ
- ◯ Cone biopsy
- ◯ Total hysterectomy
- ◯ Sub-total hysterectomy
- ◯ Other (enter below)

Urgent test results

For urgent results provide contact name and phone number

Name	
Phone	

Laboratory identifiers *(Lab to complete)*

Date received by Lab	dd mm yyyy

Requestor details

Practitioner name

Health Practitioner Indicator (HPI)

Health Facility Name

Health Facility Number (HPI)

Additional copy of results to

Date taken dd mm yyyy

Signature of Practitioner / Sample taker

Additional comments

For private specialist colposcopists and oncologists only

Is this a screening sample?

- ◯ Yes
- ◯ No