# **Colposcopy Outpatients E-Referral Proforma**

**Please do not use this form for 2 week target cancer referrals**

All referrals to services at St George’s Healthcare NHS Trust should be made directly via ERS. Please be aware that we no longer accept any referrals outside of ERS.

**Please note that if any \* starred items are not completed the referral cannot be processed until the completed information is obtained.**

|  |  |  |
| --- | --- | --- |
| **\*Today’s date:**  | **\*Speciality: *Colposcopy*** | **Lead Consultant: *Mr Paul Carter*** |
| **PATIENT PERSONAL DETAILS** |
| **\*NHS number** | Hospital No If Known: |
| \*Title | \*Surname | \*Forenames(s) |
| \*D.O.B:  |  | \*Gender: *Female* |  |
| \*Address |
| \*Postcode |
| Telephone (Home) | Telephone (Work) |
| \*Telephone (Mobile) | *\*Please give at least one contact number – mobile preferable* |
| \*Patient has been resident in the UK for the last 12 months? | *Yes* | *No* | *N/k* |
| \*Interpreter required? | Yes  | No | *If yes, which language?* |
| Special/Mobility needs |
| **If your patient requires hospital transport, they should contact the Transport Assessment and Booking (TAB) Team as soon as their appointment has been arranged on 020 8725 0808** |
| **\*GP DETAILS** | **\*ETHNIC BACKGROUND** |
| \*GP | *Please tick one*

|  |  |  |  |
| --- | --- | --- | --- |
| White British | o | Any Other Asian Background | o |
| White – Irish | o | Black Caribbean | o |
| Any Other White Background | o | Black African | o |
| Mixed – White and Black Caribbean | o | Any Other Black Background | o |
| Mixed – White and Black African | o | Chinese | o |
| Mixed – White and Asian | o | Any other Ethnic Group | o |
| Any Other Mixed Background | o |  |  |
| Indian | o |  |  |
| Pakistani | o |  |  |
| Bangladeshi | o |  |  |

 |
| \*Practice name |
| \*Address |
| \*Postcode |
| \*Telephone |
| \*Fax |
| **CLINICAL DETAILS** |
| \*Comprehensive clinical details and reasons for referral  |
| \*Details of any tests requested/awaited/enclosed with the referral e.g. smear etc. |
| \*Medication/Allergies |
| **\*Smear Taker/Referral Sender Details****\*Name:****\*Address:****\*Contact Number:** |
| ***FOR OFFICE USE ONLY*** |
| *ORE’ing/Prioritisation Stamp* |