# **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* | | | | | | | | | | | | |