Dartmouth Health

Dartmouth Hitchcock Medical Center

Phone: (603) 653-9300
Fax: (603) 676-4080
Medically Urgent Fax: (603) 640-1909

Referring Provider: _____ Office Phone: _____

Practice Name: _____ Fax: _____

Practice Address _____PCP Name: _____

Patient Name: _____ MRN# _____

DOB: _____ Cell Phone _____ Home Phone _____Work Phone _____

Mailing Address: _____

Will a supplied interpreter be needed for this appointment? ❑ No ❑ Yes Language:_____

Health Insurance: _____Subscribers Name: _____

Policy #: _____ Group# _____ Subscribers DOB _____

Referral for General Obstetrics & Gynecology | Evaluation of Abnormal Pap and/or Colposcopy

Please include any pertinent records including Pap smear results, pathology reports, or relevant office notes unless available in CIS.

*For women 20 years or younger: if Pap is ASCUS or LSIL, repeat Pap in 12 months (even if HPV positive); if that Pap (#2) is ASCUS or LSIL, repeat again in 12 months; if repeat (#3) is still abnormal, refer for colposcopy.

Current Pap Smear:

Date of Pap Smear: _____

❑ Normal Pap with persistent High Risk HPV positive
❑ ASCUS with positive High Risk HPV
❑ LSIL
❑ HSIL
❑ AGUS
❑ Other: _____

Prior Treatment for Abnormal Pap? ❑ Yes ❑ No

If yes, please describe: _____

Is patient pregnant? ❑ Yes ❑ No

If yes, please provide EDD: _____

Reason for Request (please check only one):

❑ **Consultation & Colposcopy:** Colposcopy and other evaluative testing will be performed, if indicated.

We will follow up with the patient and formulate and execute treatment plans. The patient will be returned to you for decisions regarding all other aspects of her care, including follow-up pap smears and other gynecological care.

❑ **Other** (describe): _____

Preferred Day of Week:

M T W T F ❑ AM ❑ PM

Please note: we strive to meet these requests, but may not always be able to do so.

Is the patient aware of this referral so she may be contacted by our office? ❑ Yes ❑ No

Would your office like notification of this appointment? ❑ Yes ❑ No