REFERRAL TO FAMILY PLANNING NSW COLPOSCOPY CLINIC – fax to 02 8752 4392

family planning nsw
Reproductive & Sexual Health

Client Details

Name: _____

Address: _____

Medicare number: _____ Date of birth: _____

Telephone (Mob) _____ (H) _____ (W) _____

Referrer Details

Doctor's name: _____

Practice address: _____

Telephone number: _____ Fax: _____

Clinical Information

Recent cervical screening result & date: (*Please attach copy*)

_____

_____

_____

Previous cervical screening history: (*Please attach copy of results*)

_____

_____

_____

Past history of treatment to cervix: (*Please attach details*)

_____

_____

_____

Other relevant clinical information:

_____

_____

_____

Doctor's Signature: _____

Date: _____