

PATIENT INFORMATION :

Patient Name : _____ Date of Birth : / / yr
 IC : _____ Age / Gender : _____ / _____ Clinic/Hospital Ref. No : _____
 Race : Malay / Chinese / Indian / Others _____ Smoker : Yes / No

Test requested	Purpose	Normal	Specimen	Symptoms
<input type="checkbox"/> LBC <input type="checkbox"/> HPV DNA <input type="checkbox"/> LBC + HPV DNA <input type="checkbox"/> Others _____	<input type="checkbox"/> Routine <input type="checkbox"/> Pregnant <input type="checkbox"/> Postnatal <input type="checkbox"/> Post-irradiation <input type="checkbox"/> Menopausal <input type="checkbox"/> IUCD present <input type="checkbox"/> L.M.P. _____	<input type="checkbox"/> Ectropion <input type="checkbox"/> Cervicitis <input type="checkbox"/> Polyp <input type="checkbox"/> Malignant <input type="checkbox"/> Cautery	<input type="checkbox"/> Vaginal Pool <input type="checkbox"/> Cervical scrape <input type="checkbox"/> Endocervical swab <input type="checkbox"/> Lat. Vag. wall scrape <input type="checkbox"/> Others: _____ _____ _____	<input type="checkbox"/> Leucorrhoea/Pruritus <input type="checkbox"/> Abnormal discharge <input type="checkbox"/> Coital/contact bleeding <input type="checkbox"/> Monilia <input type="checkbox"/> Trichomonas <input type="checkbox"/> Senile vaginitis <input type="checkbox"/> Others _____

REFERRING DOCTOR'S NAME, ADD, TEL AND FAX :	Clinical Diagnosis or reason to test :

Doctor's copy