REFERRAL FORM

MOH Area

1. Full Name :
2. Age :
3. Address / Contact No :
4. NID No. :
5. Identification No (Same as the slide) :
6. Name of the Clinic :
7. LRMP : Date Month Year
8. Specimen Type :

Present — First Smear — Date

Follow up

Previous — Date — Slide No :

Normal — Abnormal

Diagnosis of previous smear :

Treatment

9. Symptoms

- Discharge
- Post- Coital Bleeding
- Inter- menstrual Bleeding
- post- menopausal Bleeding
- Other (Specify)

10. Appearance of Cervix

- Normal
- Abnormal (Comment)
  - Malignant
  - Cervicitis
  - polyps

11. Condition

- Pregnant
- Post-natal (12/52)
- IUCD inserted
- Oral contraceptive
- Menopause
- Other hormones (Specify)

Comments : .....

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Date : .....

Signature : .....

Designation : .....

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