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

Revised 2010

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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