**Support to screening referral form - Cervical Screening**

**Priority group patient details**

**Patient name and personal details**

First name(s):

Surname:

NHI: ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: ­

Home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone number:

Physical address:

Please advise how many attempts have been made to contact the patient:

Please tick to confirm that you have checked the contact details are up to date:

Does patient smoke? Circle Y / N

**Patient eligibility information**

1. *Please tick which group patient belongs to* (*Maori, Pacific, Asian women 20-69 years. Any other women 30–69 years)*

Maori  Pacific Island  Asian  Other (please state): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. *Please tick which statement is correct:*

Patient has never had a cervical smear (*unscreened*)

**or**

Patient has not had a cervical smear in the previous five years (*significantly overdue*)

Date of last smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result of last smear:

Smear history if available:

**Comments/Useful information**

**Referrer and GP practice contact information**

Referrers Name & Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GP name:

GP practice:

GP practice contact phone number:

Practice postal address: