Cancer Services Program of the Finger Lakes Region

Colposcopic Examination Notes

Name: _____ Exam Date: _____

DOB: _____

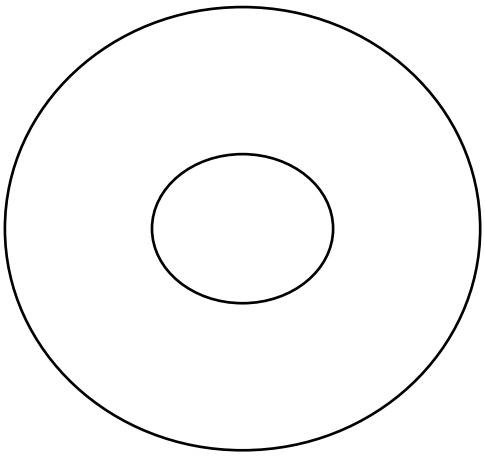
Pap Test date: _____ Result: _____

Examination Zone:

__ Fully Visualized __ Not Fully Visualized __ Unsatisfactory

Biopsy: Yes _____ No: _____ If yes, sites: _____

ECC: Yes _____ No: _____



Colposcopic Diagnosis : _____

Histology Report: _____

Plan:

Repeat pap in _____

Treatment Plan :

Cryosurgery* _____

Laser* _____

LEEP* _____

Cone* _____

Hysterectomy* _____

* These services are not covered by the Health Partnership of Monroe County. Please make patient aware that she needs to contact our office to apply for the Medicaid Cancer Treatment Program.

Is she having an appointment to start treatment?

Yes _____ No _____

If yes:

When: _____ Where: _____

If you have any comments, please use the back of this form.

Doctor/Practice Name: _____

MD Signature: _____ Date: _____

Please include pathology report and treatment plan. Thank you !

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