Cervical Cancer Histopathology Request Information

Family name

Given name(s)

Date of birth

Date of request

DD – MM – YYYY

DD – MM – YYYY

Patient identifiers

e.g. MRN, IHI or NHI (please indicate which)

Ethnicity

☐ Unknown

☐ Aboriginal/Torres Strait Islander

☐ Other ethnicity:

Requesting doctor - name and contact details

Copy to doctor name and contact details

Tumour location

Operative procedure

☐ Cone biopsy (laser cone or cold knife cone biopsy)

☐ Radical trachelectomy

☐ Hysterectomy

☐ Radical hysterectomy

☐ Other

Accompanying specimens

☐ Lymph nodes

☐ Other

Clinical diagnosis

Previous biopsy or cytology results

New primary or recurrence

☐ New primary cancer

☐ Distant metastasis

☐ Local recurrence

Details:

Previous treatment

Details of prior cancer diagnosis

Family history

Existence of local residual cancer

Principal clinician

Version 1.0 Request Information from Cervical Cancer Structured Reporting Protocol 1st Edition