**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:

**Patient eligibility information**

1. *Please tick which group patient belongs to* (*Māori, Pacific, CSC 20-69 years. Any other women 30–69 years unscreened or never screened)*

 [ ]  Māori [ ]  Pacific Island [ ]  CSC Holder [ ]  Other:

1. *Please tick which statement is correct:*

[ ]  Patient is 30yrs or over and has never had a cervical smear (*unscreened*)

[ ]  Patient is 30yrs or over and has not had a cervical smear in the previous five years (*significantly overdue*)

[ ]  Patient requires follow up

**Comments/Useful information**

**Referrer and GP practice contact information**

Referrers Name & Role:

GP name:

GP practice: