

HMR101 Request/Report Form
OPEN EXETER 2003 version, updated December 2011

Box No.	Information Required	Usage Instructions
Box 01	Woman's hospital registration number	Record the woman's locally-allocated hospital or unit number (if applicable).
Box 02	Laboratory	Record the name or site of the laboratory which will be reporting the sample.
Box 03	Woman's surname Previous surname First names Full postal address Postcode	Record the key demographic information of the woman to provide up-to-date contact details. This information is also necessary for patient identification and therefore allows the laboratory to link previous results with this test.
Box 04	Date of Birth	Record the woman's actual date of birth to indicate her age and also to assist in patient identification and record linking. The woman's age will affect interpretation of the test and is therefore significant.
Box 05	NHS number	Record the woman's NHS number. This should be a 10-digit number displayed in a 3-3-4 format. This is required for patient identification and is particularly useful to support electronic data communications.
Box 06	Name and address of sender if not GP (If hospital state consultant, clinic or ward, and hospital) Postcode	Record the name and address of the organisation where the sample taker is based (if this is not the woman's own GP practice).
Box 07	Name and address of GP Postcode	Record the name and address of the woman's GP. If the woman is not currently registered with a GP, this should be noted. Increasingly patients are registered with a practice rather than a specific GP and so a GP name will not always be available.
Box 08	Health Authority Practice code GP's local code GP's national code	Record the appropriate codes to identify the woman's GP (where applicable), GP practice and HA system. The HA system refers to the PCO/Agency NHAIS database identifier. This is the system on which a woman is registered based on her postcode of residence, and is the system to which the laboratory must send the woman's screening result to allow a result letter to be generated. In areas where one laboratory routinely sends results to multiple PCO databases, provision of the correct HA name/code will ensure that results can be sent directly to the correct system and so result letters to women will not be delayed. Local GP/GP practice codes are unique only within one PCO area. They are useful for local reference but caution may be required in fringe areas where identical codes may be used on neighbouring systems to refer to different GPs or practices. National practice codes are unique, stable and recognised by all national systems including the NHS Personal Demographics Service (PDS). National codes are preferred for the identification of a patient's GP/GP practice.

Box 09	Source of sample: 1 = GP 2 = NHS community clinic 3 = GUM clinic 4 = NHS hospital 5 = Private 6 = Other 7 = NHS colposcopy	Indicate which type of organisation the sample taker is acting for at the time of this test. Code 1 (GP) is to be used for any sample taken by a direct employee of the GP practice, regardless of the location e.g. home visit. The sample taker may be the GP, a practice nurse or other qualified health professional. Code 2 (community clinic) is to be used for samples taken at local NHS clinics e.g. family planning clinics. Code 3 (GUM clinic) is to be used for samples taken at GUM or other sexual health clinics. Code 4 (NHS hospital) is to be used for samples taken at hospital clinics such as maternity clinics. Sample taken under GUM, at colposcopy or where the woman is being treated/screened as a private patient are excluded. Also excluded are samples from GP or community clinics on hospital premises. Code 5 (Private) is to be used for any sample from a private patient. Code 6 (Other) is to be used for samples from sources which are not otherwise classifiable e.g. workplace or charitable screening services. Code 7 (NHS colposcopy) is to be used for screening or follow-up tests taken at NHS colposcopy clinics. Note that only samples from source types 1 and 2 are classed as screening samples for the purposes of evaluation of the NHS Cervical Screening Programme.
Box 10	Local codes: (1 - 6)	This box is to be used by local arrangement only.
Box 11	Code number of laboratory	Record the laboratory identification code.
Box 12	Slide serial number	Record the slide identification number. This information is required for record linkage and to facilitate audit. Where screening is carried out by HPV test alone, this box will record the accession number of the sample within the laboratory system rather than a slide number.
CLINICAL REPORT		
Box 13	Date of this test	Record the date that the sample was taken from the woman.
Box 14	Date of LMP (1st day)	Record the date that was the first day of the woman's last menstrual period. This information together with date of test is required for the laboratory to calculate the exact day of the menstrual cycle which influences the interpretation of the sample, particularly in older women. Date of LMP should therefore be given as accurately as possible. If the woman is amenorrhic (e.g. post-menopausal, pregnant, using Depo Provera), the best estimate (month and/or year) of the LMP should be given. This, together with consideration of the woman's age and hormonal status (see box 19), will also influence the interpretation of the sample.
Box 15	Date of last test	Record the date of the woman's last test (if applicable)

		and/or if known).
Box 16	If no previous test, put X in box	Indicate if the woman has never had a test before, adequate or inadequate. Do not mark this box if there is uncertainty about the existence of a previous test.
Box 17	Reason for test: 1 = routine call 2 = routine recall 4 = previous abnormal test 5 = previous inadequate test 6 = opportunistic 7 = follow-up after treatment 3 = other	Indicate the reason for the test, selecting one option only. This information will be used for detailed evaluation of the NHS Cervical Screening Programme from 2003. <p>Code 1 (routine call) is to be used for women responding to an invitation for routine screening who have never before had an adequate test, regardless of the number of previous invitations. See note 1 below.</p> <p>Code 2 (routine recall) is to be used for women responding to an invitation for routine rescreening. The woman's last attended test is likely to have been coded 'A' (routine recall) for next action. See note 1 below.</p> <p>Code 4 (previous abnormal test) is to be used where a woman is undergoing repeat screening due to a previous borderline or mildly abnormal result which was coded 'R' (early repeat) for action. This abnormal result may have been some months or years earlier and may have been followed by one or more subsequent negative tests. However, until the woman is returned to routine recall, code 4 should continue to be used. Code 4 may also be used for next samples from women who were referred for colposcopy due to one or more abnormal samples (any degree of abnormality) but who did not attend.</p> <p>Code 5 (previous inadequate test) is to be used where a woman's previous result was inadequate (result code '1') and the reason for the previous test was not known. Otherwise a repeat test for a previous inadequate should be coded according to the original reason for the test. Code 5 should also be used for:</p> <ul style="list-style-type: none"> - samples from women referred for colposcopy following a series of inadequate tests; - next samples from women referred for colposcopy following a series of inadequate tests but who did not attend. <p>Code 6 (opportunistic) is to be used for samples from women who are eligible for routine call/recall (i.e. no previous test or no recent test which was abnormal) but who are not responding to a formal invitation for screening. This may include women who are tested while ceased from the programme e.g. those who have opted out. See note 1 below.</p> <p>Code 7 (follow-up after treatment) is to be used where a woman requires cytological surveillance after a colposcopy attendance regardless of whether or not the colposcopy resulted in biopsy/treatment. Cytological surveillance is usually indicated by the 'R' (early repeat) action code. If a woman is returned to routine recall after negative colposcopy (action code 'A'), code 7 should not be used for subsequent tests.</p>

		<p>Code 3 (other) is to be used for samples which do not fit into any other category, for example samples taken at first visit to colposcopy.</p> <p>Note 1 An invitation is defined as a written letter notifying a woman that her test is due. The screening service, the GP practice or the laboratory may send invitations. A woman attending for screening within six months of the date of invitation is considered to be responding to that invitation. Attendances more than six months after a routine invitation should be classed as opportunistic (code 6). Attendances at any time after an early repeat invitation should be classed according to the reason for the repeat e.g. previous abnormal (code 4) or follow-up (code 7).</p> <p>If the date and/or type of the woman's most recent invitation are not known and cannot be estimated based on her known screening history, it is acceptable to assume that the test is opportunistic (code 6).</p>
Box 18	Not used	
Box 19	<p>Condition (if applicable): 1 = pregnant 2 = post-natal (under 12 weeks) 3 = I.U.C.D. fitted 4 = taking hormones (specify in 20)</p>	Indicate which (if any) of the options are applicable and provide details where necessary in box 20. This information is required by the laboratory as the woman's hormonal status influences interpretation of the sample.
Box 20	<p>Clinical data 1 = Cervical scrape 2 = Other (specify) _____</p>	<p>Indicate the type of specimen.</p> <p>Provide all information relating to current signs and symptoms. Also provide brief details of any significant history including abnormal cytology (with slide number) and previous diagnosis and treatment. This will ensure that the laboratory has sufficient information to make an appropriate recommendation on future management of the woman.</p>
	<p>Sample taker signature Sample taker code:</p>	Sign and provide sample taker identification code (by local agreement only).
Box 21	CYTOLOGY REPORT	Provide a full report using free text or standard report codes according to local practice.
Box 22	<p>Cytological pattern: 1 = inadequate specimen N / 2 = negative B / 8 = borderline changes M / 3 = mild dyskaryosis 7 = moderate dyskaryosis 4 = severe dyskaryosis 5 = severe dyskaryosis/ ?invasive carcinoma 6 = ?glandular neoplasia</p>	Indicate the cytological pattern of the sample, selecting one option only.
Box 23	<p>Specific infection: 1 = trichomonas 2 = candida 3 = wart virus</p>	<p>Indicate which, if any, infections are present in the sample (by local agreement only).</p> <p>Codes 0, 9 and U will be used where HPV triage has</p>

	<p>4 = herpes 5 = actinomyces 9 = HPV Positive 0 = HPV Negative U = HPV Unavailable 6 = other (specify)</p>	<p>been introduced to local screening programmes. HPV triage is now being rolled out across England. See www.cancerscreening.nhs.uk for more information.</p>
Box 24	<p>Management suggested: 1 = normal recall 2 = repeat test in __ months 3 = repeat test after treatment 4 = gynaecological referral 5 = cancel recall</p>	<p>Indicate the next recommended action, selecting one option only.</p> <p>Code 1 (normal recall) is to be used for all cases where the next test is due at the routine recall interval which may be up to 54 months. This corresponds to action code 'A'.</p> <p>Code 2 (repeat in 'm' months) is to be used where the next test is due at an early or fixed interval. This corresponds to action code 'R'.</p> <p>Code 3 (repeat after treatment) is to be used where, for example, the test cannot be reported due to infection. This corresponds to action code 'R'.</p> <p>Code 4 (gynaecological referral) is to be used where the woman requires a referral for colposcopy or where she has been referred and is to remain under the colposcopist's care pending return to call/recall. This corresponds to action code 'S'.</p> <p>Code 5 (cancel recall) is no longer used. The laboratory may not remove a woman from call/recall. If code 5 is selected it is treated in the same way as code 1. Note that a woman whose next test would become due after age 65 will be removed from call/recall automatically provided that there are no indications to the contrary, for example a recent abnormal screening result.</p>
	<p>Signature Date</p>	<p>Sign and give the date that the sample was reported.</p>