compass
Future directions in cervical screening

VCS Pathology

MEDICARE CARD NUMBER

PATHOLOGY REQUEST

Patient Surname | Given Names | Gender | Date of Birth | Your Reference

Patient Address

Previous Surname

LAB COPY

Tests Requested

- ☐ Recruitment test
- ☐ Follow-up test
- ☐ Other

*Ref: wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

Clinical Notes

Do not send to My Health Record ☐

Is the patient of Aboriginal or Torres Strait Islander origin?

- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Aboriginal and Torres Strait Islander
- ☐ Not Aboriginal or Torres Strait Islander

In which country was the patient born?

Does the patient speak a language other than English at home? *(If more than one language, indicate the one that is spoken most often)*

☐ No, English only ☐ Yes, other

(please specify)

Tick only where appropriate

Abnormal bleeding ☐ No ☐ Yes _____ (specify)

Appearance of cervix ☐ Normal ☐ Abnormal _____ (specify)

Specimen site ☐ Cervix ☐ Other _____ (specify)

Pregnant/Post partum ☐

Hysterectomy ☐

IUCD ☐

Same day colposcopy ☐

CST taken by nurse ☐

Practitioner No. if not requesting practitioner

Urgent ☐ Phone ☐ Fax ☐ By Time: _____

Phone/Fax No. _____

Private ☐ Schedule ☐ Bulk Bill ☐ (Complete Medicare Assignment)

Vet Affairs No. _____

Practitioner's Signature

X

Date

/ /

COPY REPORTS TO:

Requesting Practitioner
(Provider number, Surname, Initials and Address)

Patient status at the time of the service or when the specimen was collected

	Yes	No
Private patient in a private hospital or approved day hospital	☐	☐
Private patient in a recognised hospital	☐	☐
A public patient in a recognised hospital	☐	☐
Outpatient of a recognised hospital	☐	☐

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973).

I assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s)

☐ practitioner only (please tick). Reason patient unable to sign. _____

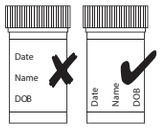
Patient's Signature

X

Date

/ /

Complete patient surname, given name and date of birth prior to attaching to specimen. PLACE LABEL VERTICALLY. If more than 3 specimens write patient details on additional specimens.



Date	Date	Date
Name	Name	Name
DOB	DOB	DOB

Compass Trial: Study Participant Consent Form - Participation involves the following:

Researchers are allowed to access my relevant medical records • I am aged at least 25 and born on or after 1st July 1980 • My participation in the trial is entirely voluntary and I can withdraw at any stage. This will not affect my relationship with my health practitioner, VCS Pathology or Cancer Council NSW • Any information relating to my participation in the study is strictly confidential. I agree that the results can be published, provided I cannot be identified • Any residual samples will be stored and may be used for the development of new HPV testing technologies. Ethical approval will be obtained prior to undertaking any further research studies using these samples. I understand that I will not have access to these test results • If I have any questions I can contact the Compass trial hotline on 1800 611 635 or visit www.compasstrial.org.au • If I have any concerns or complaints about the study, I can contact the Research Governance Officer, Bellberry Limited on 08 8361 3222 • I may be contacted in the future and asked to complete a questionnaire or receive a study newsletter • I understand that the Compass Register will undertake the usual functions of the National Cancer Screening Register • I consent to the Compass investigators opting me out of receiving correspondence from the National Cancer Screening Register, on my behalf • I understand that I will be followed on the Compass register for the duration of the trial. I agree to participate in the Compass Trial and understand that I will be followed for 5 years. • I understand I will be randomly allocated to having my cervical screening sample tested by one of two methods; cytology (the test used up until December 2017 in the cervical screening program) or HPV DNA testing (the new test used from December 2017)

☐ I do **not** wish for my left-over cervical sample to be used for any further research or for any HPV test validation purposes.

NATA
Accredited for compliance with NPAAC Standards and ISO 15189

RCPA
The Royal College Pathologists of Australasia

WOMAN ID

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P: 03 9250 0300 F: 03 9349 1949

[name] *please print clearly* _____

of [address] _____

have been invited to participate in Compass Trial, a randomised controlled trial of cervical screening in Australia. I acknowledge that I have received and read the information sheet. I have had the opportunity to ask questions and they have been answered to my satisfaction. I understand that participation in the Compass Trial involves consenting to aspects of the trial described above.
Relevant medical records include: records stored on Australian Jurisdictional Pap test registers and the National Cancer Screening Register, the National HPV Vaccination Program Register, relevant Australian Jurisdictional Cancer Registers, and the Registries of Births, Deaths and Marriages.

Name | Phone | Signature | Date

Email | Mobile

X

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