

# Cervical Screening Audit

Please complete all sections below. Please note: Supplying your RACGP/ACRRM/RANZCOG/ACN number and email address is vital for us to accurately allocate your education points.

## DOCTOR INFORMATION

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Laverty Dr. Code (if known): \_\_\_\_\_ Provider No.: \_\_\_\_\_

Name of College: \_\_\_\_\_ College Registration No.: \_\_\_\_\_

**Mandatory**

### Practitioner Type

- General Practitioner
  General Practitioner specialising in Women's Health  
 Sexual Health Clinic
  Obstetrician and Gynaecologist
  Nurse Practitioner

## PRACTICE DETAILS

Practice Name (Primary Location): \_\_\_\_\_

Practice Address (Primary Location): \_\_\_\_\_

Suburb: \_\_\_\_\_ State: \_\_\_\_\_ Postcode: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Required**

Other practice locations to be included in this audit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I, Dr \_\_\_\_\_ (print name) confirm that I wish to receive a 'Cervical Screening Audit Report' of my pathology cases and I will contact Laverty Pathology if my contact details change or if I no longer want to receive the 'Cervical Screening Audit Report'.

Doctor's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**Please Note:** It is recommended that specimens be submitted on **pale green** Cervical Screening Test Request forms which are available via your Medical Liaison Officer, your stores network or your nearest laboratory.

Complete, scan and email or fax this registration form to [Marketing@laverty.com.au](mailto:Marketing@laverty.com.au) / (02) 9770 1050

