Annex: Sample VIA Screening Form

Name of Screening Centre

PERSONAL DETAILS & CONTACT INFORMATION		
1.	Unique registration ID (National ID, if available):	[ ][ ][ ][ ][ ][ ]
2.	Date of registration (day/month/year):	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]
3.	Last name:	_____
4.	First name:	_____
5.	Husband's/Partner's name	
6.	Age:	[ ][ ]
7.	Date of birth (day/month/year):	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]
8.	Address:	_____ _____ _____
9.	Telephone number:	[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]
10.	**REGISTRATION NUMBER (Screening programme)**	

REPRODUCTIVE HISTORY		
1.	Age at marriage *(in years)*: *(99. If unknown)*	[ ][ ]
2.	Total number of pregnancies: *(99. If unknown)*	[ ][ ]
3.	Last menstruation: *(1. Less than 1 year; 2. More than 1 year; 9. Unknown)*	[ ]
4.	Date of onset of last menstruation	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]

VIA PROCEDURE		
1.	SCJ visible: *(1. Fully visible; 2. Partially visible; 3. Not visible)*	[ ]
2.	Findings of VIA: *(1. Not done; 2. Negative; 3. Positive; 4. Suspicious of invasive cancer)*	[ ]
3.	If positive, size of the acetowhite area (% of ectocervix): *(1. <25%; 2. 25–50%; 3. 50–75%; 4. >75%)*	[ ]
4.	Can the lesion be covered by the cryotherapy probe? (if cryo is used to treat) *(1. Yes; 2. No)*	[ ]
5.	Is the lesion suitable for cryotherapy/thermal ablation? *(1. Yes; 2. No)*	[ ]

TREATMENT		
1.	Type of treatment done: *(1. Not required; 2. Thermal ablation; 3. Cryotherapy; 4. LLETZ; 5. CKC; 6. Refused; 7; Not done due to other reason)*	[ ]
2.	Problem during thermal ablation: *(1. None; 2. Pain; 3. Bleeding; 4. Other_____)*	[ ]
3.	Follow-up date	[ ][ ]/[ ][ ]/[ ][ ][ ][ ]

REFERRAL		
1.	Reason for referral *(1. VIA +ve & requires further management; 2. Suspicious of cancer; 3. Other _____)*	[ ]
2.	Referred to:	

Name of Health Worker/Nurse **Signature & date**