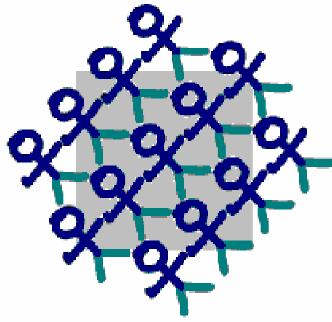

NEW SOUTH WALES
Pap Test Register

CERVICAL SCREENING DATA REQUEST

Name of person making request: ______________________________

Professional status: ______________________________

Name of practice: ______________________________

Address: ______________________________

____

Post Code: ____________________

Phone No: ____________________ **Fax No:** ____________________

I would like to request patient information from the Register using the following provider No/s:

DOCTOR'S FIRST NAME	DOCTOR'S SURNAME	PROVIDER NO.

SIGNATURE: ____________________ **DATE:** ____________________

NSW PAP TEST REGISTER
Locked Bag 3, Woolloomooloo, NSW 2011 Phone: (02) 8374 5692 Fax: (02) 8374 5695