HMR101 Request/Report Form

Introduction

The HMR101 is the standard request form used for cervical screening tests. There are a number of different versions available including several options available through Open Exeter (which are produced within the GP practice), printed multi-part forms and locally-designed alternative forms (which may be produced by a cytology laboratory). There are also equivalent systems for requesting tests electronically e.g. ICE. The cytology laboratory will advise which version of the form they prefer for tests sent to them.

The 2009 version of the HMR101 available from Open Exeter can be printed complete with a woman's demographic details and screening history as recorded on the screening call/recall system (NHAIS). This is likely to be the preferred option in many areas.

Completing the form

Many aspects of the forms are common to all variants and methods of requesting. The following information relates to the 2009 version of the HMR101 available from Open Exeter. Where data fields are common to other systems the same comments apply.

Box No	Information Required	Usage Instructions
Box 01	**Woman's hospital registration number**	Record any local hospital number used to identify the patient. Does not include NHS number – see box 05.
Box 02	**Laboratory**	Record the name of the laboratory.
Box 03	**Woman's surname** Previous surname First names Full postal address Postcode Phone number	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. If a mobile phone number is recorded and this may be used for text messaging, ensure that the patient is informed that this will happen.
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) at the time of this test.

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Box No	Information Required	Usage Instructions
Box 07	**Name and address of GP** Postcode	Record the name and address of the woman's GP practice. If the woman is not currently registered, this should be noted.
Box 08	**Health Authority** **Practice code** **GP's local code** **GP's national code** **NHAIS district code**	Record the appropriate codes to identify the organisations responsible for a woman and the code of the NHAIS district (which is used to determine the applicable screening protocol i.e. Triage and Test of Cure or HPV Primary Screening) on the call/recall 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 or the GP practice with which she is registered), and is the one to which the laboratory must sent 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 are 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 is 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 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 samples taken by a direct employee of the GP practice, regardless of the location. 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 clinic. **Code 4** (NHS Hospital) is to be used for samples taken at hospital clinics such as maternity clinics. Samples 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

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		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**	To be used by local agreement only.
Box 11	**Code number of laboratory**	Record the laboratory's national organisation code.
Box 12	**Slide serial number**	Record the accession number of the sample.
CLINICAL REPORT		
Box 13	**Test date**	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 the 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 amenorrheic (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	**Last test**	Record the date of the women'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. Pre-printed forms should indicate in this section if the woman is in a district subject to the HPV Primary Screening protocol.

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Box No	Information Required	Usage Instructions
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. **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. **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. **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. **Code 5** (previous inadequate test) is to be used where a women'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: - 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. **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. **Code 7** (follow-up after treatment) is to be used where a woman requires cytological surveillance after a colposcopy

Box No	Information Required	Usage Instructions
		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 also be used for subsequent tests. **Code 3** (other) is to be used for samples which do not fit into any other category, for example at first visit to colposcopy. **Note 1** An invitation is defined as a written letter notifying a woman that her test is due. A woman attending for screening within six months of the date of invitation is considered to be responding to that invitation. Attendance more than six months after a routine invitation should be classed as opportunistic (code 6). Attendance 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). If the date and/or type for 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).
Box 18	**Not used**	
Box 19	**Condition (if applicable):** 1 = pregnant 2 = post-natal (under 12 weeks) 3 = I.U.C.D. fitted 4 = taking hormones (specify in 20)	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.

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Box No	Information Required	Usage Instructions
Box 20	**Clinical data**	Indicate type of specimen.
	Specimen type 1 = Cervical scrape 2 = Other (specify)	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.
	Screening history	Pre-printed forms should give all known previous screening test results in this section automatically.
	Date	Record the date of completion of the form.
	Sample taker signature **Sample taker code**	Sign the form and give the appropriate identification code e.g. GMC or NMC code.
Box 21	**CYTOLOGY REPORT**	Provide a full report using free text or standard report codes according to local practice. Note that infections identified in a sample may be reported only by local agreement. Infections are not part of the screening programme.
	Signature **Date**	Sign and give the date that the sample was reported.