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| Cervical Screening Programme Deferral |

This form should be used if a participant's next test is to be postponed. The reason for postponement and new deferral date must be specified.

The participant will be invited for screening approximately 5-6 weeks before the end of the deferral period.

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| Participant Full Name\* | Click here to enter text. |
| Participant NHS Number\* | Click here to enter text. |
| Participant Date of Birth\* | Click here to enter a date. |
| Participant Address\* | Click here to enter text. |

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| Please defer until (DDMMYYY)\*  (See below for maximum deferral months) | Click here to enter a date. |

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| Deferral Reason (Please select only **one**)\* |
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| Practice details | | | |
| Doctors/Nurse/Clincian signature\* |  | | |
| Full Name (Printed)\* | Click here to enter text. | Date:\* | Click to enter a date. |
| Practice Name\* | Click here to enter text. | GP National Code:\* | Click here to enter text. |
| Practice Address\* | Click here to enter text. | | |

Next steps for Practices: Once completed and signed, please upload this form via the CSAS website. You should use the online enquiry form on the ‘Contact Us’ page and select the ‘Defer’ option. Keep the original copy in your files.

***Please note that fields marked with an asterisk (\*) are mandatory***