Name

D.O.B

# Cervical screening: extra support required

Dear nurse, some things listed on this page may affect my experience. I may need extra support because *(tick any boxes that describe your situation):*

☐ I have a mental health condition

☐ My medication makes me shake

☐ I find it hard to leave my house

☐ I sometimes find it hard to process information

☐ I don't like to feel exposed or naked

☐ I am embarrassed about my body

☐ I have scars

☐ I feel judged

☐ I feel like a burden

☐ I am afraid it will hurt

☐ I may start to cry or freeze up

☐ I may pass out or faint

☐ I may have a panic attack

☐ I get distressed during a physical examination

☐ I have had a bad smear test experience

☐ I have experienced trauma

☐ I am a survivor of sexual violence

☐ I am a survivor of female genital mutilation/cutting (FGM/C)

☐ I want to be warned before the nurse touches me

☐ Waiting rooms make my symptoms worse

☐ These words can trigger attacks or flashbacks *(please list those words here)*:

☐ Other

If you have any other comments, please add them below: