BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

Colon Screening Program

Assessment Form

INSTRUCTIONS: *Fax page 3 to the Colon Screening Program*

PATIENT NAME _____ **DATE OF BIRTH** *(dd/mm/yy)* _____ **PHN** _____

PATIENT'S PREFERRED NAME _____ **ASSESSMENT DATE** *(dd/mm/yy)* _____

Alerts for Colonoscopy:

- ☐ Anticoagulation
- ☐ Antiplatelet agent
- ☐ Defibrillator/Pacemaker
- ☐ Diabetic insulin/tablets
- ☐ Sleep Apnea
- ☐ Iron tablets *(stop 5-7 days)*
- ☐ Glaucoma
- ☐ COPD
- ☐ CHF
- ☐ Contact Precaution (specify): _____
- ☐ Significant co-morbid illness
- ☐ Allergies/sensitivities
- ☐ No blood transfusions
- ☐ Renal insufficiency/dialysis

Comments_____

_____

_____

Reason for Colonoscopy Assessment: ☐ + FIT _____ng/ml ☐ + Family History ☐ Surveillance/Deviation

_____

Medication	Dose	Frequency	Medication	Dose	Frequency	Medication	Dose	Frequency

Allergies: ☐ NKA

_____

_____

Symptoms (within last 6 months)	No	Yes	Comments
BM Frequency *(specify)*			
Recent changes in bowel habits			
Diarrhea			
Constipation			
Rectal bleeding			
Bowel urgency			
Unexplained weight loss			
Abdominal pain			
Upper GI Symptoms *(eg. N&V, swallowing difficulties, GERD)*			

Comments: _____

_____

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PATIENT NAME _____ **DATE OF BIRTH** *(dd/mm/yy)* _____ **PHN** _____

Medical History	No	Yes	Comments
Gastrointestinal *(eg.Ulcers, Barrets, Hiatus hernia, Diverticular disease)*			
Hx colonoscopy or flexible sigmoidoscopy			
Surgery *(eg.Abdominal and other)*			
Cardiac *(eg.A. Fib, Pacemaker, ICD, CHF)*			
Hypertension			
Respiratory *(eg.Sleep apnea, asthma, COPD)*			
Liver			
Renal *(eg.document eGFR <60ml/min, creatinine >100umol/L, if known)*			
Diabetes *(eg.Type 1/ 2, Insulin, oral Hypoglycaemic)*			
Glaucoma			
Epilepsy			
Stroke			
Cancer			
Bleeding disorder			
Blood transfusion concerns *(eg.Jehovah's witness)*			
Problems with sedation or anaesthesia			

Comments / Other Medical Concerns:

_____

_____

_____

Patient lives: ☐ Alone ☐ With (Specify): _____

Do you consider yourself to have a disability? ☐ No ☐ Yes

☐ Mental health difficulty ☐ Dyslexia ☐ Mobility ☐ Progressive disability (eg MS) ☐ Learning disability

☐ Blind/partially blind ☐ Deaf/HOH ☐ Other *(specify):* _____

Smoker: ☐ No ☐ Yes #/day: _____ Quit date *(approximate)*: _____

EtOH: ☐ No ☐ Yes units/week: _____

Recreational or illicit Drug Use: ☐ No ☐ Yes Substance: _____Frequency:_____

Height (cm): _____ **Weight (kg):** _____ **BMI:** _____

21001

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Colon Screening Program

Affix Label Here

Assessment Form

INSTRUCTIONS: *Fax page this page to the Colon Screening Program 1-604-297-9340*

PATIENT NAME _____ **DATE OF BIRTH** *(dd/mm/yy)* _____ **PHN** _____

Date Patient 1st Contacted *(dd/mm/yy)* _____ **Assessment date** *(dd/mm/yy)* _____ **Amended Ax date** *(dd/mm/yy)* _____

Assessment ☐ In Person ☐ By Phone ☐ Patient Not Contacted

FOR ALL PATIENTS

Family History: 1st degree relative CRC: ☐ No ☐ Yes ☐ More than three 1st degree Relatives

_____ *Relative* _____ *Age at Diagnosis*

_____ *Relative* _____ *Age at Diagnosis*

_____ *Relative* _____ *Age at Diagnosis*

Any relatives with HNPCC connected Cancers? ☐ No ☐ Yes

(*specify*): _____

_____

_____

☐ **Patient proceeding to colonoscopy as part of the Colon Screening Program**

1st available date *(dd/mm/yy)* _____ **Booked date** *(dd/mm/yy)* _____ **Procedure Location** _____

Patient teaching

☐ Appointment details provided
☐ Procedure explained
☐ Bowel prep explained
_____
☐ Sedation options discussed
☐ Risks/complications discussed
☐ Transportation home discussed, ride to be provided by: _____

Patient instructions (if applicable)

☐ Advised to discontinue iron 5-7 days prior
☐ Diabetics - patient aware to consult w/ GP or specialist regarding fasting & medications
☐ Antithrombotics - patient aware to discuss with GP/specialist when to stop medications
☐ Pacemaker - ensure hospital protocols are met for these patients

Teaching date/time: _____
Teaching Coordinator: _____

☐ **Patient NOT proceeding to colonoscopy as part of the Colon Screening Program** *(please specify):*

Communication provided to GP/NP

☐ Crohn's or ulcerative colitis
☐ Colorectal cancer history
☐ Symptomatic, GP/NP to refer to specialist
☐ Outside the target age
☐ Medically unfit
☐ Family history does not meet colonoscopy eligibility
☐ Not due for colonoscopy screening/surveillance/follow-up
_____ ☐ FIT ☐ Colonoscopy
(*specify future date*) mm/yy
☐ Patient declined
☐ Unable to contact patient
☐ Other (specify) _____

☐ **Patient is not proceeding at this time but a future recall is required - future date (mm/yy):** _____ ☐ FIT ☐ Colonoscopy

☐ Colonoscopist consult required: _____ ☐ HCP Referral: _____

Comments: _____

_____

_____ **Patient Coordinator Name**

_____ **Patient Coordinator Signature**

_____ **Location**

PATIENT NAME _____ **DATE OF BIRTH** (*dd/mm/yy)* _____ **PHN** _____

Date	Notes