



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:

- | | | |
|---|--|--|
| <input type="checkbox"/> Anticoagulation | <input type="checkbox"/> Iron tablets (stop 5-7 days) | <input type="checkbox"/> Significant co-morbid illness |
| <input type="checkbox"/> Antiplatelet agent | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Allergies/sensitivities |
| <input type="checkbox"/> Defibrillator/Pacemaker | <input type="checkbox"/> COPD | <input type="checkbox"/> No blood transfusions |
| <input type="checkbox"/> Diabetic insulin/tablets | <input type="checkbox"/> CHF | <input type="checkbox"/> Renal insufficiency/dialysis |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Contact Precaution (specify): _____ | |

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: _____



Colon Screening Program

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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:** _____



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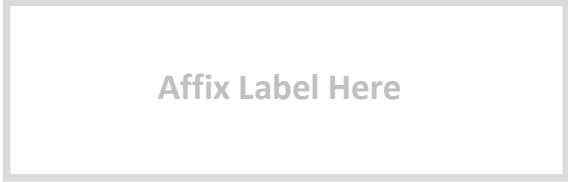


BC Cancer Agency

CARE + RESEARCH

An agency of the Provincial Health Services Authority

Colon Screening Program



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

_____	_____	Any relatives with HNPCC connected Cancers? <input type="checkbox"/> No <input type="checkbox"/> Yes
Relative	Age at Diagnosis	(specify): _____
_____	_____	_____
Relative	Age at Diagnosis	_____
_____	_____	_____
Relative	Age at Diagnosis	_____

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

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

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