Colon Screening Program
Standards: Patient Coordinator Model

VERSION: 22MARCH2016
Colon Screening Program

This report was produced by the Colon Screening Program at the BC Cancer Agency

Preferred citation:

For more information please contact:
Colon Screening Program
801-686 West Broadway
Vancouver, BC
V5Z 1G5

Web: www.screeningbc.ca/colon
Email: screening@bccancer.bc.ca
Phone: 1-877-70-COLON (26566)
Fax: 1-604-877-6103
Acknowledgements

The BC Cancer Agency (BCCA) would like to thank everyone who assisted in the development and refinement of the Colon Screening Program’s Standards: Patient Coordinator Model.

Co-authors
Dr. Jennifer J. Telford, BC Cancer Agency
Dr. Denis Petrunia, Vancouver Island Health Authority

Contributors
Sheila Campbell, Vancouver Island Health Authority
Dr. Justin Cheung, Fraser Health Authority
Dr. Martin Fishman, Vancouver Coastal Health Authority
Laura Gentile, BC Cancer Agency
Judith Hockney, Fraser Health Authority
Laura Johnston, Northern Health Authority
Dr. Brian Tighe, Interior Health Authority

It has been the innovative and transforming work of the Colon Screening Program’s Colonoscopy and Patient Coordination Working Group that inspired and informed the development of these guidelines. We would also like to thank the management of the BCCA Screening Programs, the BCCA executive sponsors of the Colon Screening Program, the Provincial Health Services Authority (PHSA), the Ministry of Health, the BC Society of Gastroenterology, the Section of General Surgery, the Society of General Practitioners of BC, the BCCA Gastrointestinal (GI) Tumour Group, and the Colon Screening Program Advisory Committee.

About the BC Cancer Agency
The BC Cancer Agency, an agency of the Provincial Health Services Authority, provides a comprehensive cancer control program for the people of BC in partnership with regional health authorities. This includes prevention, screening and early detection programs, research and education, and care and treatment.

The BC Cancer Agency’s mandate is a three-fold mission:
• To reduce the incidence of cancer
• To reduce the mortality rate of people with cancer
• To improve the quality of life of people living with cancer

This mission drives everything we do, including providing screening, diagnosis and care, setting treatment standards, and conducting research into causes of, and cures for, cancer.
Table of Contents

Introduction 1.1 Colon Screening Program
1.2 Purpose of the Standards
1.3 Sources of Information
1.4 General Principles

Qualifications 2.0

Pre-Colonoscopy Assessment 3.1 Direct Observation of Procedural Skills
3.2 Assessment and Patient Education
3.3 Bowel Preparation

Alerts for Colonoscopy 4.1 Pre-colonoscopy Assessment
4.2 Antithrombotic Therapy
4.3 Cardiac Defibrillator
4.4 Diabetes
4.5 Iron tablets
4.6 Glaucoma
4.7 Renal insufficiency/dialysis
4.8 Congestive Heart Failure (CHF)

Informed Consent 5.0

Post Colonoscopy Assessment 6.1 Telephone Follow-up at 14 Days
6.2 Unplanned Events
6.3 Re-screening and Surveillance Guidelines

Quality Assurance 7.1 Data Collection
7.2 Patient Coordinator Performance Indicators

8.0 References

Appendix

A Patient Coordinator Assessment Form
B Colonoscopy Brochure
C Sample Not Proceeding to Colonoscopy Letter
D Unplanned Events Form
E Follow-Up Form
F Colonoscopy Reporting Form
1. Introduction

1.1 Colon Screening Program
Colorectal cancer (CRC) is the third most common cancer and the second leading cause of cancer death in Canada and in other developed countries\(^1\). The Colon Screening Program seeks to reduce the incidence and mortality of colorectal cancer by providing timely and equitable access to high quality screening and diagnostic services to eligible men and women ages 50 to 74 in BC.

1.2 Purpose of the Standards
Patient Coordinators are Regional Health Authority nurses who play an essential role in the Colon Screening Program. These Standards are designed to maximize participant safety and program efficiency and efficacy by ensuring the Patient Coordinator role is clearly understood and carried out in an effective, consistent manner across the province.

1.3 Sources of Information
The Standards: Patient Coordinator Model are based on the experiences of the BC Cancer Agency Colon Check pilot program, the Vancouver Island Health Authority Pilot Program and the NHS Bowel Cancer Screening Programme (UK).

1.4 General Principles
- Early detection reduces colon cancer incidence and mortality.
- The application of evidence informs policy, system design and ongoing management and clinical decision making.
- The planning and delivery model is based on population distribution data and is responsive to the needs of the entire eligible population in British Columbia.
- Services are delivered by suitably trained, competent and qualified clinical and non-clinical staff.
- Services delivered are safe, effective, of high quality and quality assured.

2. Qualifications
Clinical aspects of the patient coordinator model (e.g. clinical assessment and patient teaching) must be completed by a registered nurse, preferably with experience in patient education. Supportive components of the model (e.g. booking patients for assessment, faxing information, completing the procedure booking process) can be done by clerical support staff as deemed appropriate by the health authority). When required, specialist precolonoscopy assessment must be completed by a specialist who meets the Colonoscopist qualifications in the Standards: Colonoscopy.
3. Pre-colonoscopy Assessment

3.1 Program Criteria
The eligibility criteria for the Colon Screening Program are:
- ages 50-74
- asymptomatic

Patients are referred to the program by health care providers. Health care providers are provided with information on the eligibility criteria for the program and it is expected that providers consider and adhere to the criteria. However, some health care providers will, at times, refer patients through the program who are outside of the age range or who have symptoms.

If received by the BC Cancer Agency, the agency will refer patients with abnormal FIT results or family history criteria on to the patient’s health authority for assessment. The BC Cancer Agency is supportive of collecting all data and outcomes for these patients, by completion of the usual model, for patients who are outside the program age range or who may present to the patient coordinator with symptoms.

The program also recognizes that health authorities or endoscopy units may want to manage these patients through a different route (e.g. health authority routes referral to specialist for full consult and colonoscopy booking, if appropriate, through the specialist’s office).

As such, page 3 of the Patient Coordinator Assessment Form provides options for either retaining the patient in the program for assessment, colonoscopy and follow-up or for indicating back to the BC Cancer Agency that the patient will not be followed by the program. For patients who will not be followed by the program, please indicate option “Not proceeding: assessment/colonoscopy to occur outside of the program” on page 3 of the Patient Coordinator Assessment Form.

The identification of patients who do not meet screening program criteria may occur at the time of referral from the BC Cancer Agency to the health authority or through the patient assessment process. Recall processes for patients who are registered and followed by the program for their screening episode are outlined in the Standards: Colonoscopy.
3.2 Assessment and Patient Education

- Contact referred patients and establish time to complete assessment. Each Regional Health Authority will determine whether the assessment takes place by telephone, in person or through group education sessions. Self reported height and weight is acceptable for phone assessments.

- Complete the Patient Coordinator Assessment Form (see Appendix A).
  - Identify any high risk factors that require colonoscopist assessment prior to colonoscopy and refer patient as indicated. See Section 3 and Patient Assessment Process document.
  - Send page 3 of the Patient Coordinator Assessment Form to the BC Cancer Agency.

- Provide education to the patient regarding:
  - Implications of an abnormal FIT and the reasons for colonoscopy follow-up.
  - Bowel preparation and colonoscopy.
  - Explain the risks of colonoscopy.
  - Provide the patient with the Colon Screening Program Colonoscopy brochure (sample in Appendix B) to inform them about colonoscopy.
  - Give the patient written bowel preparation instructions, based on the assessment and the colonoscopist’s preference.

- Book patient for colonoscopy:
  - If not proceeding to colonoscopy, advise GP using Not Proceeding to Colonoscopy letter, Appendix C

- Patients who do not proceed to their colonoscopy within 6 months of the Patient Coordinator assessment should be re-assessed prior to proceeding to colonoscopy.

3.3 Bowel Preparation

Participants should be provided with instructions for one of the following three bowel preparations: polyethylene glycol (PEG), magnesium citrate and sodium picosulfate. See Bowel Preparation Decision Algorithm for further information on bowel preparation selection.


Recent studies have indicated that split-dose bowel preparations improve the quality of the bowel preparation as compared to bowel preparations administered the day prior to colonoscopy and this has led to a significant increase in the adenoma detection rate\(^1\). PEG based preparations now come in low volume options and cause less electrolyte or volume shift than hyperosmolar preparations such as sodium pico-sulfate and magnesium citrate.

Indications for a PEG based preparation:
- Renal insufficiency
- Cardiac disease
- Cirrhosis
- Consider in the elderly and patients on diuretic therapy
4. Alerts for Colonoscopy

4.1 Pre-colonoscopy Assessment
A pre-colonoscopy questionnaire is a useful tool to identify patients being considered for colonoscopy and polypectomy who may be at increased risk, see Patient Coordinator Assessment Form (Appendix A).

Pre-existing medical conditions and medications may conflict with safe bowel preparation, medications used for sedation, electrocautery equipment or be associated with increased risk of complications.

Each individual is unique and the clinical circumstances with each patient prevent clear guidelines as to appropriate adjustments required in every circumstance of identified increased risk. When in doubt as to the appropriate action, the patient’s family physician and/or the attending colonoscopist should be consulted for clinical direction.

If any of the following conditions exist, then the patient coordinator should alert the colonoscopist and the participant may require a consultation prior to colonoscopy. The participant may also see the colonoscopist prior to the colonoscopy at their request.

GI Symptoms
- Rectal bleeding
- Chronic diarrhea
- Persistent change in bowel habits
- Chronic abdominal pain
- Unexplained weight loss

Significant co-morbid medical illnesses
- Cancer
- Dialysis patients
- Insulin-dependent diabetics
- Bleeding disorders and patients on antithrombotics
- Cardiac disease requiring a pacemaker or defibrillator
- Respiratory disease requiring home oxygen or CPAP
- Congestive heart failure
- Current angina or history of a myocardial infarction
- Morbid obesity (BMI ≥ 40)

Other
- Participant who will not consent to blood products (e.g. Jehovah’s Witness)

4.2 Antithrombotic Therapy
Antithrombotic agents are medications that prevent blood clot formation and can be divided into anticoagulants and antiplatelet agents. These medications may increase a patient’s risk of bleeding following colonoscopic polypectomy. Non-steroidal anti-inflammatory medications...
(e.g. ibuprofen, naproxen) are not prescribed to prevent clot formation but as a side effect they do inhibit platelet function and increase the bleeding time. Prospective studies have concluded that aspirin and non-steroidal anti-inflammatory medications can be safely continued for colonoscopy and polypectomy.

Whether a medication is discontinued prior to undergoing colonoscopy involves balancing the risk of bleeding following polypectomy and the risk of clotting if the antithrombotic medication is discontinued. Patients on antiplatelet agents (aside from aspirin), anti-thrombin agents and anticoagulants should be reviewed by their health care provider prior to the colonoscopy to decide timing of the colonoscopy, discontinuation of the antithrombotic agent, the need for bridging anticoagulation and when the antithrombotic agent can be restarted. These decisions may be made in conjunction with the patient’s family physician, cardiologist or neurologist.

The following are examples of anticoagulants and antiplatelet agents with the Canadian brand names in brackets. New antithrombotic agents may be available in the near future so this list should not be considered exclusive.

**Anticoagulants**
Warfarin (Coumadin)
Heparin
Low-molecular weight heparin
  - Enoxaparin (Lovenox)
  - Dalteparin (Fragmin)
Fondaparinux (Arixtra)
Dabigatran (Pradax)
Rivaroxaban (Xarelto)
Apixaban (Eliquis)
Desirudin (Iprivask)

**Antiplatelet agents**
Aspirin
Cilostazol (Pletal)
Thienopyridine agents
  - Clopidogrel (Plavix)
  - Ticlopidine (Ticlid)
  - Prasugrel (Effient)
  - Ticagrelor (Brilinta)

**4.3 Cardiac Defibrillator**
Implantable cardiac defibrillators are increasingly common and may be activated inadvertently during endoscopy if electocautery is used.

Most patients with cardiac pacemakers may undergo routine uses of electocautery (i.e. polypectomy) with no alterations in management. Some standard precautions are necessary during the procedure to minimize risk.
In all patients with implanted cardiac devices, determine the type of cardiac device, indication for the device and degree of pacemaker dependence before endoscopy. Most patients carry a wallet card, which identifies the device and contact numbers.

In patients with cardiac defibrillators, consultation with cardiologist is recommended and deactivation of the device by qualified personnel should be considered. Continuous cardiac monitoring during the procedure is recommended. The device should be reprogrammed as soon as possible after the procedure.

4.4 Diabetes
Diabetic patients may experience difficulty with glucose control during the bowel preparation and required fasting prior to colonoscopy. Most patients on oral agents (e.g. Metformin (Glucophage), Glipizide (Glucotrol), Glyburide (Diabeta/Micronase), Pioglitazone (Actos), Rosiglitazone (Avandia), Acorbose (Precose) or Miglito (Glyset)) can safely continue the medications until their usual diet is interrupted. During fasting and the bowel preparation time, the drugs should be held. Drugs should be restarted when oral intake is resumed after the procedure.

Patients requiring insulin will need to reduce the insulin dosage during fasting for the bowel preparation and day of the colonoscopy procedure. Most patients on insulin have been educated on how to adjust their own insulin during periods of fasting. Patients should be asked to consult with their physician ahead of the procedure.

Patients with diabetes are at increased risk of renal disease and should be questioned as to any pre-existing renal impairment, as this would impact the type of bowel preparation that would be recommended.

4.5 Iron tablets
Oral iron compounds interact with colonic mucous and dietary compounds and impair the effect of bowel preparations. Patients should be advised to discontinue oral iron preparations at least 7-10 days prior to the procedure. Even oral vitamins containing iron are best discontinued to improve colonoscopy quality.

4.6 Glaucoma
Glaucoma (an optic neuropathy due to increased intro-ocular pressure) is present in ~1-8% of individuals over 40 and more common in diabetics. Patients with increased intraocular pressure or glaucoma are often treated with topical eye drop medications. Glaucoma can be aggravated by anti-cholinergic drugs, which are occasionally used during endoscopic procedures to reduced smooth muscle spasm. Glaucoma is usually well controlled with topical medications, which should be continued, and does not interfere with colonoscopy or polypectomy. Anti-spasmodic drugs should be avoided during the procedure.

4.7 Renal insufficiency/dialysis
Patients with impairment of renal function can be adversely affected by the dehydrating potential of colonoscopy bowel preparations. Patients with significant kidney disease (i.e. eGFR of less than 60ml/min) should be offered an electrolyte solution containing Polyethylene glycol
(PEG) for bowel cleansing.

Patients receiving dialysis who require colonoscopy present challenges for safe, effective bowel preparation that does not seriously affect their fluid balance. Colonoscopy is best scheduled in consultation with the patient’s nephrologists to discuss bowel preparation and appropriate timing of the procedure in relation to the patient’s dialysis times.

Routine antibiotic prophylaxis is not recommended prior to colonoscopy. Antibiotic prophylaxis prior to colonoscopy is recommended for patients undergoing continuous peritoneal dialysis to prevent peritonitis. A single dose of ampicillin plus an aminoglycoside may be given intravenously just prior to the colonoscopy. Intraperitoneal antibiotics the night prior to colonoscopy is an alternative strategy. The abdomen should be emptied of fluid prior to colonoscopy.

4.8 Congestive Heart Failure (CHF)
Patients with congestive heart failure may be at increased risk of complications related to colonoscopy bowel preparation and should be offered the PEG based bowel preparations. Patients with severe congestive heart failure, which causes shortness of breath on exertion or significantly limits activity, require a medical consult before colonoscopy should be considered.

5. Informed Consent

Requirements for written informed consent will differ according to the institution. The Colon Screening Program “What is a Colonoscopy?” brochure provides information on the risks of colonoscopy. This must be provided to each patient, in addition to any institution specific consent requirements. It’s important that the patient be given time to process the consent information and ask questions. The patient coordinator will provide the participant with the information necessary to give informed consent. The colonoscopist will obtain consent prior to the procedure.

Colonoscopy has a 5/1000 risk of a serious complication. This includes the following:
Reaction to the bowel preparation
▪ Reaction to the medication used for sedation
▪ Cardiopulmonary event
▪ Infection
▪ Bleeding (<1/1000)
▪ Perforation (<1/1000)

The chance of death from colonoscopy is 1/14,000.

The chance of a significant abnormality being missed is 1/10.

Additional information to answer participant’s questions is provided below.
▪ Cardiopulmonary event refers to desaturation, low blood pressure and rarely angina or myocardial infarction.
6. Post Colonoscopy Assessment

6.1 Telephone Follow-up at 14 Days
Fourteen days after the procedure, the patient coordinator will contact the patient. The purpose of the 14-day telephone interview is to:
- assess for any unplanned events following colonoscopy and
- recommend the next re-screening or surveillance interval

6.2 Unplanned Events
Any unplanned event occurring the day before or following colonoscopy should be recorded using the Unplanned Event Form (Appendix D). A serious adverse event is an adverse event that results in a hospitalization or death. Please provide any pertinent reports (operative, pathology, radiology, discharge summary).

6.3 Re-screening and Surveillance Guidelines
The patient coordinator should review the patient’s pathology report and the recommendations in the Colonoscopist’s Procedure Report. If recommendations differ from the re-screening or surveillance guidelines outlined in the Colonoscopy Standards document, then the next recommended screening type and interval should be discussed with the colonoscopist.

Complete the Follow-Up Form (Appendix E) based on the guidelines and colonoscopist’s recommendations and fax the form to the BC Cancer Agency. The BC Cancer Agency will generate a letter outlining findings and re-screening/surveillance recommendations to be sent to the family physician, colonoscopist and patient coordinator.

Deviations in the recommendations are appropriate under certain circumstances. Examples are in the Colonoscopy Standards.

The only reasons for a participant to leave the Colon Screening Program are for age > 74 years, a diagnosis of colorectal cancer and a diagnosis of ulcerative or Crohn’s colitis. All other participants should continue to be screened in the Colon Screening Program and if their screening needs to be individualized, then this can be done by citing a deviation and explanation on the follow-up form.

- Infection refers to phlebitis related to the IV, pneumonia (aspiration), and diverticulitis. Infection can be transmitted by the colonoscope between patients or from a contaminated water supply. If infection is transmitted between patients, it indicates an error has occurred in the colonoscope cleaning.
- Bleeding is almost always at the site of a polyp removal. It is usually self-limited but will occasionally require hospital admission with a repeat colonoscopy, blood transfusion or surgery.
- Perforation usually is at the site of a polyp removal. It almost always requires surgery.
While there may be an indication to do a colonoscopy at an earlier interval, there is never an indication to do a FIT at an earlier interval. If a colonoscopy is not high quality the patient should have a repeat colonoscopy as soon as possible and certainly within 1 year.

If the colonoscopist disagrees with the Colon Screening Program's recommendations and decides upon a different FIT follow-up interval for a patient who has undergone a high quality colonoscopy, then this will need to be arranged by the colonoscopist outside of the Colon Screening Program. Unfortunately, the primary care provider will receive two different recommendations - those in the colonoscopy report and those from the program.

Regarding patients with an abnormal FIT and a colonoscopy without a cancer or polyp, the patient will be recalled to undergo repeat FIT in 10 years. Follow-up forms received by the program that indicate a deviation with FIT prior to the 10 year recall will not have the deviation entered and the follow-up letter to the Colonoscopist, Patient Coordinator and GP will indicate rescreening or surveillance based on current guidelines.

7. Quality Assurance

7.1 Data Collection

Each colonoscopy unit will need a quality program in place. The BC Cancer Agency will have a central database where the Performance Indicators will be maintained and reported back to Health Authorities. By providing complete and accurate information on the relevant forms, patient coordinators will help with appropriate data collection for Performance Indicator and patient outcome monitoring.

The Colonoscopy Reporting Form, Appendix F, must be used to record details of the procedure. This form is completed in addition to the hospital’s standard dictated or synoptic report. If a synoptic report is available and provides the level of detailed outlined in the Colonoscopy Reporting Form, the synoptic colonoscopy report may be used in lieu of the Colonoscopy Reporting Form. Endoscopy units interested in using only a synoptic report need to provide a copy to the BCCA for review to ensure all data elements will be accessible for data entry. Reporting standards for colonoscopy procedure reports are outlined in the Colonoscopy Standards document.

7.2 Patient Coordinator Performance Indicators

- Number of patients not proceeding to colonoscopy due to poor medical fitness
- Compliance with follow-up colonoscopy
- No show rate for colonoscopy
- Time from positive FIT to colonoscopy
- Number of patients deemed medically unfit by colonoscopist at time of colonoscopy (i.e. prepped for procedure but medically unfit)
- Bowel preparation quality
- Patient, GP, colonoscopist satisfaction with patient coordinator role
- Time from referral to first attempted patient contact by patient coordinator
8. References


### Appendix A - Patient Coordinator Assessment Form

**Assessment Form**

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

<table>
<thead>
<tr>
<th><strong>PATIENT NAME</strong></th>
<th><strong>DATE OF BIRTH (dd/mm/yyyy)</strong></th>
<th><strong>PHN</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PATIENT’S PREFERRED NAME</strong></th>
<th><strong>ASSESSMENT DATE (dd/mm/yyyy)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Alerts for Colonoscopy:**
- Anticoagulation
- Antipatelet agent
- Defibrillator/Pacemaker
- Diabetic insulin/tablets
- Sleep Apnea
- Iron tablets (stop 5-7 days)
- Glaucoma
- COPD
- CHF
- Contact Precaution (specify): __________

**Comments:** __________

**Reason for Colonoscopy Assessment:**
- [ ] FIT _______ ng/ml
- [ ] Family History
- [ ] Surveillance/Deviation

### Medication

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies:** [ ] NKA

**Symptoms (within last 6 months)**

<table>
<thead>
<tr>
<th><strong>Symptoms</strong></th>
<th><strong>No</strong></th>
<th><strong>Yes</strong></th>
<th><strong>Comments</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>BM Frequency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent changes in bowel habits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constipation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel urgency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained weight loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdominal pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper GI Symptoms (eg. N&amp;V, swallowing difficulties, SERD)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comments:** __________

---

**Colon Screening Program | Page 1 of 4 | FORM: 21001 | VERSION: 12NOVEMBER2014 | 805 606 West Broadway | Vancouver, BC | VS2 1C1 | 1-877-70-COLON | www.screnningbc.ca**

Colon Screening Program Patient Coordinator Standards 22 Mar 2016 (R)
Colon Screening Program

Patient Name

Medical History

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal (e.g., ulcers, tumors, hernias, diverticulosis)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History colonoscopy or flexible sigmoidoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery (e.g., abdominal and other)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac (e.g., AFib, Pacemaker, ICD, CHF)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory (e.g., asthma, COPD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal (e.g., albumin &lt;40mg/dL, creatinine &gt;200umol/L, if known)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes (e.g., Type I, II, insulin, oral hypoglycaemics)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion concerns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jehovah's Witness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with sedation or anesthesia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 (e.g., 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: □

Colon Screening Program Patient Coordinator Standards 22 Mar 2016 (R)
# Assessment Form

INSTRUCTIONS: Fax this page to the Colon Screening Program 1-604-297-9240

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH (dd/mm/yy)</th>
<th>PHN</th>
</tr>
</thead>
</table>

Date Patient 1st Contacted (dd/mm/yy): 
Assessment date (dd/mm/yy): 
Amended At 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 | Any relatives with HNPC connected Cancers? [ ] No [ ] Yes
--- | --- | ---
Relative | Age at Diagnosis | (specify)
Relative | Age at Diagnosis |

<table>
<thead>
<tr>
<th>Patient proceeding to colonoscopy as part of the Colon Screening Program</th>
</tr>
</thead>
</table>

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: 
Transportation to be provided by: 
Teaching date/time: 
Teaching Coordinator: 

## FOR ALL PATIENTS (please specify)

Communication provided to GP/NP: 
- Crohn’s or ulcerative colitis
- Colorectal cancer history
- Symptomatic, CP/NP to refer to specialist

Outside the target age: 
- Patient declined
- Unable to contact patient

Family history does not meet colonoscopy eligibility: 
- Other (specify)

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

Colonoscopy consult required: 
HCP Referral: 
Comments: 

<table>
<thead>
<tr>
<th>Patient Coordinator Name</th>
<th>Patient Coordinator Signature</th>
<th>Location</th>
</tr>
</thead>
</table>

21001

Colon Screening Program Patient Coordinator Standards 22 Mar 2016 (R)
<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH (dd/mm/yy)</th>
<th>PHN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix B - Colonoscopy Brochure

What is a Colonoscopy?
Colonoscopy is a procedure that allows a colonoscopist to see the inside lining of the rectum and colon using a special instrument called a colonoscope.

A colonoscopy is a flexible tube with a miniature camera attached to one end so that the colonoscopist can take pictures and videos of your colon. During a colonoscopy, tissue samples can be collected and abnormal growths can be removed.

Who needs a colonoscopy?

- Two or more first-degree relatives (mother, father, sister, brother, daughter or son) diagnosed with colon cancer at any age.
- One first-degree relative diagnosed with colon cancer under the age of 60.
- A personal history of adenoma(s).
- You may also be referred for colonoscopy if you have had an abnormal fecal immunochemical test (FIT).

What happens during a colonoscopy?

1. A colonoscopist inserts the colonoscope into the rectum and advances it along the length of the colon.
2. Air is sent through the colonoscope to expand the colon for better viewing.
3. Images of the lining of the rectum and colon are sent to a video monitor where the colonoscopist will look for anything unusual, like a polyp.
4. A polyp is a small growth of tissue on the wall of the intestine.
5. Polyps can grow very slowly, and some can become cancerous. It may be necessary to take a sample (biopsy) or remove the polyp (polypectomy). This is painless.

Before the colonoscopy

- Expect to be at the hospital for two to three hours.
- You will be asked to change into a gown.
- A nurse will complete your admission paperwork and ensure your vital signs.
- You will be asked to provide a list of your medications.
- A nurse will start an intravenous (IV) to administer sedation and pain medication.

After the colonoscopy

- Have an adult accompany you home. You cannot drive until the following day.
- You may be sleepy after you arrive home from the procedure. It is recommended that you do not operate equipment, sign legal papers or drink alcohol until the following day.
- You will be able to resume your regular diet and medications after your colonoscopy, unless otherwise directed by your patient coordinator or colonoscopist.
- The air inside your colon may cause you to feel bloated and/or have cramping after the procedure. It is important to relax and pass the air as soon as possible. If this discomfort increases or is unrelieved, go to the emergency department and advise them that you had a colonoscopy.

Results

You will be given preliminary results before you leave the hospital. Then, approximately two weeks after your procedure, the patient coordinator or the colonoscopist will inform you of your complete results and answer your questions during the follow up call. Your doctor will also receive your results.

If your colonoscopy is normal, your personal history will determine when you will be re-screened. Your patient coordinator or colonoscopist will advise you of your next screening date.

If your colonoscopy is abnormal, further procedures or more regular surveillance may be necessary. The patient coordinator, colonoscopist, or your doctor will explain the process for further appointments and next steps.
Appendix C - Sample Not Proceeding to Colonoscopy Letter

Dear Dr. ______________________ Fax # ______________________ Date ______________________

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>PHN</th>
<th>DOB</th>
</tr>
</thead>
</table>

1. Your patient was referred for pre-colonoscopy assessment on ______________________ (date) due to:
   - Abnormal FIT
   - Family History
   - Surveillance Requirement

2. Your patient has NOT been booked for a colonoscopy procedure due to:
   - Patient has a history of inflammatory bowel disease (Crohn's or ulcerative colitis). Please refer the patient to his/her specialist for ongoing care and monitoring. The patient will not be recalled by the Colon Screening Program.
   - Patient has a history of colorectal cancer. Please refer the patient to his/her specialist for ongoing care and monitoring. The patient will not be recalled by the Colon Screening Program.
   - Patient indicated symptoms. Please refer the patient directly to a specialist for assessment. The patient will not be recalled by the Colon Screening Program.
   - Your patient does not meet the age eligibility for programmatic screening. There may be indications for screening patients over or under the target age of 50-74. If you feel this is the case, please refer your patient directly to a specialist for consideration of colonoscopy.
   - Medically unfit for colonoscopy. Colonoscopy has been deferred to ______________________ (date) and the Program will recall the patient at that time. If no date is indicated, the patient will not be recalled by the Colon Screening Program. The patient was assessed by a Colonoscopy report ______________________ (date).
   - Family history information does not meet colonoscopy screening eligibility for the Colon Screening Program. Please provide a requisition for FIT screening for this patient or refer directly to a specialist for consideration of colonoscopy.
   - Your patient does not meet eligibility for colonoscopy screening as he/she is up to date with colon screening. The patient will be recalled by the Program when he/she is next due for screening ______________________ (date).
   - Patient has an abnormal FIT but has had a colonoscopy within the past 5 years. Based on the Colonoscopy’s previous assessment, repeat colonoscopy is not required prior to this time. If the colonoscopy was done through the Program, the patient will be recalled when they are due ______________________ (date). If the colonoscopy was NOT done in the Program, we are unable to recall them. Please re-enter them to the Program when the patient is next due.
   - Patient declined proceeding to colonoscopy. The patient will not be recalled by the Colon Screening Program. If your patient elects to proceed with colonoscopy in the future, please send the Program a Colonoscopy Referral Form.
   - We were unable to reach your patient to complete a pre-colonoscopy assessment. A letter was sent to your patient to advise that they have not been booked for colonoscopy. The patient will not be recalled by the Colon Screening Program. If the patient wishes to participate in the future, please send the Program a Colonoscopy Referral Form.
   - Other ______________________

Sincerely,

[Patient Coordinator Name]

[Health Authority Name]

Colon Screening Program Patient Coordinator Standards 22 Mar 2016 (R)
## Appendix D - Unplanned Events Form

### Pre/Post Colonoscopy Unplanned

**INSTRUCTIONS:** Fax a copy to the GP, the colonoscopist, and the Colon Screening Program.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth (dd/mm/yy)</th>
<th>PHN</th>
<th>GP</th>
<th>Colonoscopist</th>
<th>Date of Colonoscopy (dd/mm/yy)</th>
</tr>
</thead>
</table>

**Date of Onset of Symptoms** (dd/mm/yy)

**Symptoms Ongoing?**

- [ ] No
- [ ] Yes

**Date of Resolution of Symptoms** (dd/mm/yy)

The day prior to, or within 14 days after undergoing a colonoscopy, this patient had these unplanned event(s):

- [ ] Bowel prep complication
- [ ] Rectal Bleeding → Anticoagulation:
  - [ ] No
  - [ ] Yes
- [ ] Perforation
- [ ] Respiratory
- [ ] Cardiac
- [ ] Infection
- [ ] Death:
  - Date of death:
  - Cause of death:
- [ ] Other (specify):

**Comments:**

Patient first obtained medical attention:

- [ ] Family Physician
- [ ] Emergency Room
- [ ] Other

**Patient required the following interventions:** (check all that apply)

- [ ] Blood transfusion
- [ ] Antibiotics
- [ ] Surgery:
  - (dd/mm/yy)
- [ ] Additional Colonoscopy:
  - (dd/mm/yy)
- [ ] Hospital admission
  - (dd/mm/yy)
  - to
  - (dd/mm/yy)

**Comments:**

Patient Coordinator Name_________________________ Patient Coordinator Contact Number_________________________

Patient Coordinator Signature_________________________ Follow-up Date_________________________

**COlON Screening Program Administrative Use Only:**

- [ ] SAE: No
- [ ] Yes
- [ ] Related to Scope: [ ] Probably
  - [ ] Possibly
  - [ ] Unlikely
- [ ] QM Review Date:_________________________

**Comments:**

- [ ] COLON SCREENING PROGRAM
  
801-686 West Broadway | Vancouver, BC | V5Z 1A1 | 1-877-70-COLON | www.screeningbc.ca

Colon Screening Program Patient Coordinator Standards 22 Mar 2016 (R)
Appendix E - Follow Up Form

Follow up Recommendations
INSTRUCTIONS: Fax a copy to the Colon Screening Program: 1-604-297-9540

<table>
<thead>
<tr>
<th>GP / NP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH (dd/mm/yy)</th>
<th>PHN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLONOSCOPIST</th>
<th>COLONOSCOPY DATE (dd/mm/yy)</th>
<th>FOLLOW-UP DATE (dd/mm/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Unplanned Events
Did the patient require medical attention the day prior to the procedure or up to 14 days after colonoscopy?
☐ No ☐ Yes ☐ Unable to contact
If yes, please complete Unplanned Event form

2) Summarization of Colonoscopy Findings (Clinical/Pathology) (Please select one option)
Hyperplastic polyp removed, other findings or no polyps found (please specify):
☐ No family history of CRC or 1 first degree relative with CRC diagnosed after age 60 (FIT rescreening in 10 years)
☐ 1 first degree relative with CRC diagnosed before age 60 or 2 or more first degree relatives with CRC at any age (Repeat colonoscopy in 5 years)
☐ Personal history of adenomas (repeat colonoscopy in 5 years)
Adenoma removed (please specify):
☐ < 1 low risk adenoma (Repeat colonoscopy in 5 years)
☐ ≥ 3 low risk adenomas or high risk* polyps removed (Repeat colonoscopy in 5 years)
* A high-risk polyp has villous features, high-grade dysplasia or is ≥ 20 mm. Sealigned/Serrated Adenomas with dysplasia and Traditional Serrated Adenomas are high risk.
Other (please specify):
☐ Colorctal adenocarcinoma identified: Recommendations per medical team. Patient no longer followed by program.
☐ Inflammatory bowel disease identified: Recommendations per medical team. Patient no longer followed by program.

3) Follow Up Recommendations (Please select one option)
☐ Follow up as per Colon Screening Program Re-Screening and Surveillance Guidelines (as above)
☐ Follow up deviates from Colon Screening Program Re-Screening and Surveillance guidelines (as below)

4) Other
☐ Patient required surgery for polyp removal
☐ Patient required CT colonography for complete visualization
☐ Normal CTC, FIT rescreening in 5 years

---

Patient Coordinator Name

Patient Coordinator Signature

Date Signed (dd/mm/yy)

---
Appendix F - Colonoscopy Reporting Form

Colonoscopy Reporting Form

PATIENT NAME (Last, First Middle) ________
DATE OF BIRTH (dd/mm/yyyy) ________
PHN ________
PROCEDURE DATE (dd/mm/yyyy) ________
PROCEDURE START TIME (24 hr) ________
HOSPITAL SITE ________
COLONOSCOPIST ________

1. DOWEL PREPARATION
   □ Excellent □ Good
   □ Fair (adequate to visualize all polyps >5mm)
   □ Poor (inadequate to visualize all polyps >5mm)

2. CECAL INTUBATION (or ileocolonic anastomosis reached)
   □ Yes □ Others
   □ Photo documentation? □ Yes □ No
   □ No □ Uncertain □ Flexible sigmoidoscopy

3. UNPLANNED EVENTS
   □ None
   □ Perforation □ Admit to hospital
   □ Bleeding □ Reversal agents
   □ Cardiovascular □ Death
   □ Respiratory □ Other (specify):

4. SPECIMENS TAKEN:
   □ Yes □ No
   □ Withdrawal Time: ________ (Minutes)

5. COMMENTS TO PATHOLOGIST:

<table>
<thead>
<tr>
<th>Specimen Type</th>
<th>Location</th>
<th>Size (mm)</th>
<th>Morphology</th>
<th>Primary Removal Mode</th>
<th>Picocel Removal Mode</th>
<th>Complete Removal (Y/N/U)?</th>
<th>Complete Removal (Y/N/U)?</th>
<th>Complete Removal (Y/N/U)?</th>
<th>Specimen (Y/N/U)?</th>
<th>Time</th>
<th>Initials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1/A</td>
<td></td>
<td></td>
<td>✓</td>
<td>P</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2/B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3/C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4/D</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5/E</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. □ Additional specimens recorded on Page 2
7. □ Repeat colonoscopy required:
   □ Patient to be re-invited by Colonoscopist
   □ Patient to be re-invited by patient coordinator (complete "Invitation on Follow Up Recommendations Form")

SEND COPIES OF PATHOLOGY REPORT TO:
1. BC Cancer Colon Screening Program
   Fax: 1 (604) 297 9340
2. SP (Name & MICC)
3. Other (Name & MICC)
4. Other (Name & MICC)

Specimens tracking required by facility: □ No □ Yes
Number of specimens sent to collection area: INITIALS DATE:
Number of specimens transported to lab: INITIALS DATE:
Number of specimens received by lab: INITIALS DATE:

PATHOLOGY COPY | FAX THIS COPY TO 1 (604) 297 9340

INFORMATION ON THIS FORM IS CONFIDENTIAL. IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO QUALITY DEPT: 1 (604) 675 7223