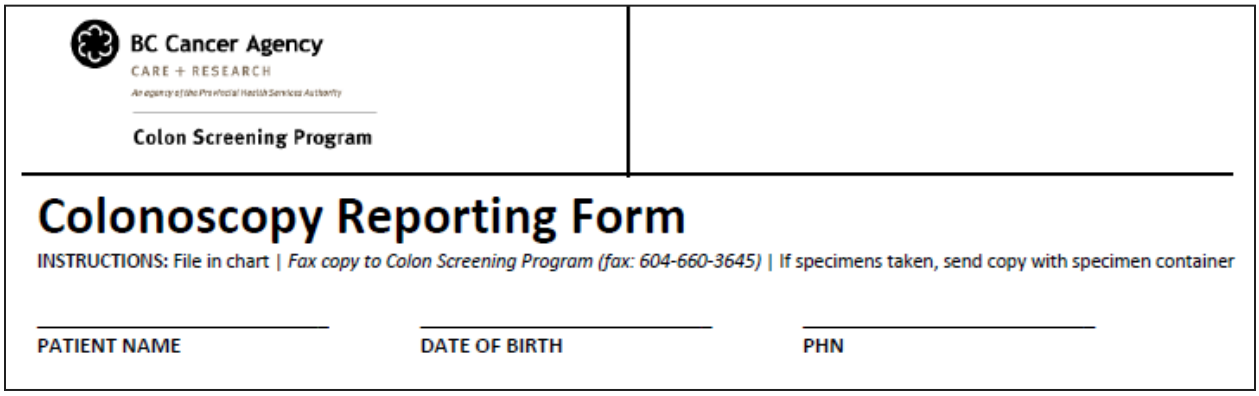
Completing the Colonoscopy Reporting Form

The Colonoscopy Reporting Form is only one component of the documentation for a Colon Screening Program participant's colonoscopy record. The original copy of the Colonoscopy Reporting Form remains in the patient chart at the hospital where the colonoscopy was completed. The form is faxed to the Colon Screening Program central office, fax number 604-660-3645 and a photocopy of the form needs to accompany any specimens that are being sent to the pathology lab. This form functions as the requisition for the pathology lab.

The Colonoscopist also dictates a procedure report for the patient chart and the family physician. A copy of the dictated report is not sent to the Colon Screening Program. Dictated reports are meant to follow the "Colonoscopy Dictation Guide" and audits will be performed intermittently to monitor adherence to the dictation guidelines.

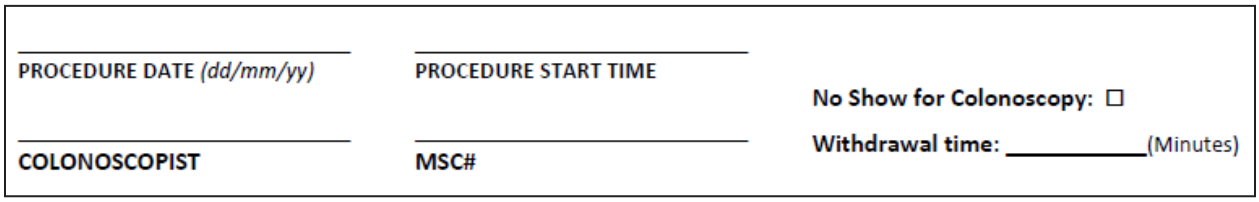

BC Cancer Agency
CARE + RESEARCH
Colon Screening Program

Colonoscopy Reporting Form

INSTRUCTIONS: File in chart | *Fax copy to Colon Screening Program (fax: 604-660-3645)* | If specimens taken, send copy with specimen container

PATIENT NAME _____ DATE OF BIRTH _____ PHN _____

Space for a hospital addressograph is provided on the top right hand corner of the form. If an addressograph is used, the patient's name, DOB and PHN must also be written in the spaces provided at the top of the form. Addressographs are not clear in photocopies and faxes and this creates problems for both the Colon Screening Program and the pathology lab. If a clear label is used, there is no need to complete the top line of the form with the patient's identifiers.


PROCEDURE DATE *(dd/mm/yy)* _____ PROCEDURE START TIME _____

No Show for Colonoscopy: ☐

COLONOSCOPIST _____ MSC# _____

Withdrawal time: _____(Minutes)

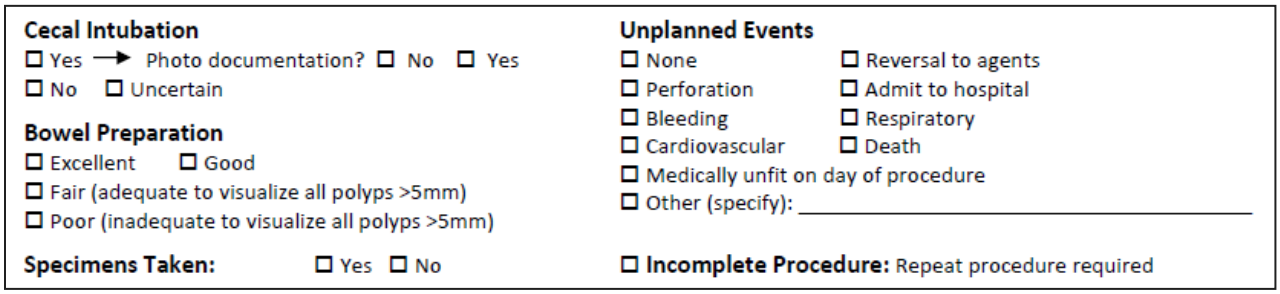
Complete the procedure date, the time the procedure started, the name of the Colonoscopist and the Colonoscopist's MSC #. The pathology lab will use the Colonoscopist as the "ordering physician" for any pathology. Correct first initial(s), last name and MSC # will help ensure the pathology lab sends the report to the correct physician.

No Show for Colonoscopy

If the patient does not show up for his/her colonoscopy and fails to inform the Patient Coordinator that he/she will not be able to attend, this absence shall be recorded as a "No Show" by ticking the box and the

Patient Coordinator will fax the Colonoscopy Reporting Form to the Colon Screening Program for documentation of this absence and rebook the patient for their procedure. The screening cycle remains open until the colonoscopy is completed or the patient declines to come back.

Withdrawal Time
Withdrawal time must be documented for each colonoscopy in which no intervention is performed (i.e. does not need to be recorded for procedures in which polypectomies are undertaken) and will be documented as a whole number (0 to 99).



Cecal Intubation
These are the quality indicators that are captured and monitored by the program. "No" for cecal intubation or a poor bowel prep should trigger another procedure to complete visualization of the colon. This could be a repeat colonoscopy or referral for a different procedure, for example CT colonography. The type of procedure selected for completing the visualization of the colon is at the discretion of the Colonoscopist and dependent on local resources. Alternative procedures will be documented on the Follow-up Recommendations Form.

If a colonoscopy is not complete (cecal intubation = No), document the withdrawal time the same as for complete scopes. It may be that less time was taken if there were difficulties with the procedure, but the complete visualization will occur with a subsequent colonoscopy or alternate procedure. If the colonoscopy was particularly difficult, it could be that the withdrawal time would be 0.

Bowel Preparation
Excellent – no more than small bits of adherent fecal material
Good – small amounts of feces or fluid not interfering with exam
Fair – adequate to detect polyps of > 5mm
Poor – inadequate to detect polyps of > 5 mm

Unplanned events
In this section, note any and all unplanned events that happen during the procedure or in the recovery area after the procedure. Mark all unplanned events that occurred. Details of the unplanned events are not captured on this form but would be outlined in the dictated procedure report completed by the Colonoscopist and the nurse's documentation at the facility.

If the patient presents at their appointment prepped for colonoscopy but is deemed medically unfit to undergo the procedure by the Colonoscopist, this as an unplanned event. Record this unplanned event on the Colonoscopy Reporting Form as "Medically Unfit on day of procedure" by ticking the associated box. Fax the Colonoscopy Reporting Form to the Colon Screening Program. The patient then needs to be reassessed for colonoscopy. Rebook if appropriate and fax the Assessment Form to the Colon Screening Program. If the patient will not be proceeding to colonoscopy document this on the Assessment Form.

The Pre/Post Colonoscopy Unplanned Event form is to be used for unplanned events taking place the day prior to the procedure or up to 14 days post procedure.

Specimens Taken
If specimens are going to be sent to the pathology lab, check the Yes box in this section and complete the table at the bottom of the form for each specimen that is taken.

Incomplete Procedure: Repeat Procedure
The "Incomplete Procedure: Repeat Procedure required" tick box refers to repeating a colonoscopy that is attempted but fails, continuing the current screening episode. An example of this being ticked would be if a patient came in for a screening colonoscopy and the bowel preparation was inadequate so had to be rebooked in the immediate future, i.e. within 2 weeks time. A second Colonoscopy Reporting Form would then be expected for the completed colonoscopy. This is to ensure that the Colon Screening Program is able to group appropriate procedures together.

	Specimen Type	Location	Size (mm)			Morphology	Primary Removal Mode	Piecemeal (Y/N)	Complete Removal (Y/N/U)	Complete Retrieval (Y/N/U)	# pieces sent
			< 5	5-9	≥ 10						
Example	**P**	**T**		**✓**		**P**	**HS**	**Y**	**Y**	**Y**	**3**
A											
B											
C											
D											
E											
F											

Specimen Type
P = polypectomy
Bx = biopsies

Y = yes
N = no
U = uncertain

Location
C = cecum
A = ascending colon
T = transverse colon
S = sigmoid
D = descending
SB = small bowel
R = rectum

Morphology
P = pedunculated
S = sessile
F = flat
M = mass
O = other

Removal Mode
BF = biopsy forceps
HBF = hot biopsy forceps
HS = hot snare
CS = cold snare

(name of person completing form)

(signature)

If specimens are going to be sent to the pathology lab, a line in the table must be completed for each specimen. Abbreviations for each column are outlined at the bottom of the Colonoscopy Reporting Form. There may be some differences between reporting a polypectomy or biopsies.

If there is no specimen to send to the lab, please mark 0 in this column, please document this as the last specimen in the table. For example if there were 3 specimens removed (A, B, C) but one of the specimens was not retrieved, please use line "C" to document the specimen with 0 pieces sent to the lab. If an un-retrieved specimen is documented on the form and further specimens are documented below, please send a labeled, empty specimen container to the lab for the specimen without a sample. This helps the pathology lab to ensure they are capturing all information at the time of accessioning and for the completed pathology report.

A second page is available for documenting specimens when more than 6 (F) specimens are taken. This form provides space for specimens G to Z.

The "comments" line provides a place for any information the Colonoscopist wishes to convey to the Pathologist regarding the specimens. It is very important to include comments for any specimens that are particularly concerning at the time of colonoscopy, for example, "biopsy of a mass of invasive carcinoma". These specifics assist the Pathologist in their assessment.

Labeling the Specimen Container:
Each specimen should be returned to the pathology lab in its own specimen container, but can include multiple pieces of the same lesion. Each container should be labeled with the following:

- addressograph stamped label or printed patient label

    - which includes the patient's name, DOB and PHN
- LETTER (A, B, C, etc.) corresponding to the line in the table where the specimen information was entered
- location the specimen was taken from (i.e. left colon)
- specimen type (i.e. polypectomy or biopsies)
- date the specimen was taken

Complete name and signature of the person completing the Colonoscopy Reporting Form.

Below is an example of how the specimen table should be completed.

	Specimen Type	Location	Size (mm)			Morphology	Primary Removal Mode	Piecemeal (Y/N)	Complete Removal (Y/N/U)	Complete Retrieval (Y/N/U)	# pieces sent
			< 5	5-9	≥ 10						
Ex	**P**	**T**		✓		**P**	**HS**	**Y**	**Y**	**Y**	**3**
A	P (polypectomy)	Denotes location where the specimen was removed from. More detailed information about where the specimen was located can be outlined in the dictated colonoscopy report.	Estimated size of the entire polyp, this will be used to help determine if an adenoma is "low" or "high" risk.			Polyp morphology: likely to be P (pedunculated), S (sessile) or F (flat).	The primary method that was used for removing the polyp.	Piecemeal denotes polyps that are removed in multiple pieces, piecemeal is not used to describe whole polyps that broke apart in the trap.	This is the Colonoscopist's impression of whether or not the entire polyp was excised.	Incomplete retrieval is documented when an entire polyp or the portion of the polyp that was removed was not retrieved and there is no sample or an incomplete sample to send to the pathology lab.	The number of pieces must be a whole number, "many" or "lots" is not an acceptable way to document this aspect.
B	Bx (biopsies)	Denotes the location where the biopsies were taken.	Estimate the size of the lesion being biopsied. For example, size of a mass or length of an area of colitits.			The description of the morphology of the lesion, likely to be M (mass) or O (other) (for example, area of inflammation).	Primary mode for obtaining biopsies, likely to be BF (biopsy forceps).	For biopsies, this would most often be Y (yes).	This is the Colonoscopist's impression of whether or not the entire lesion was excised.	Incomplete retrieval is documented when one or more biopsies of the sample were not retrieved and there is no sample or an incomplete sample to send to the pathology lab. Most likely will be Y (yes).	The number of pieces must be a whole number, "many" or "lots" is not an acceptable way to document this aspect.

Different hospitals utilize different forms. The following two sections may appear on different places on Colonoscopy reporting forms.

COPIES TO:		
Colon Screening Program Patient Coordinator	GP (name & MSC#)	Other (name & MSC#)

For the "copies to" section, the Colon Screening Program will always receive a copy of any pathology report. The hospital should complete a Colonoscopy Reporting Form with the correct hospital affiliation for the Patient Coordinator; this will help to ensure that reports are returned to the correct Patient Coordinator.

Complete the name of the GP who should also receive a copy of the pathology report and any other physician who should receive a copy. The pathology lab has a limited number of "copies to" spaces, therefore, if the number of people needing copies of the report exceeds 4, subsequent physicians will likely not receive copies of the report from the pathology lab. The Colonoscopist or the Patient Coordinator may need to send copies to these additional physicians.

FOR PATHOLOGY LAB: Number of samples received at lab: _____ Signed: _____

The "number of samples received and signed" is for accessioning purposes at the pathology lab and is not completed at the time of the colonoscopy.