BC Cancer Agency
Colon Screening Program

Documentation Guide: Page 3 of the Patient Coordinator Assessment Form

Version 1.0

Colon Screening Program

BC Cancer Agency

May 1, 2014

Table of Contents

Audience

This document contains descriptions of the data fields found on page 3 of the Patient Coordinator Assessment Form. It will assist Patient Coordinators and Clerks with filling out the data fields found on page 3 of the Patient Coordinator Assessment Form.

Introduction

The Patient Coordinator Assessment Form is completed to determine if a patient is appropriate for colonoscopy.

The majority of the data collected on the Patient Coordinator Assessment Form is for the patient's medical record at the hospital where the colonoscopy will be performed. Only page 3 of the Patient Coordinator Assessment Form is faxed to the BC Cancer Agency (BCCA) Colon Screening Program and only specific data fields on page 3 are entered into the Colon Screening Program database for monitoring and tracking.

Accurate documentation of data and completeness of the data fields on page 3 of the Patient Coordinator Assessment Form are important Patient Coordinator and Clerk responsibilities. **Do not fax page 3 of the form to the BCCA Colon Screening Program until all documentation is complete.** Patient Coordinator Assessment Forms with missing documentation or conflicting documentation will be returned to the Patient Coordinators and Clerks for correction.

Instructions specific to Page 3 are provided in this document to ensure consistent data collection for patients who are assessed at different colonoscopy centres throughout the province.

General Documentation Notes

- Write neatly, and legibly. Make sure that your writing is dark enough that it will be visible on the fax received at BCCA.
- Patient Coordinator Assessment Forms are only valid for a colonoscopy within 6 months of when the assessment form was completed.
- For patients who are having a repeat colonoscopy during a single screening episode, a second Patient Coordinator Assessment Form **does not** need to be completed.

Sample: Page 3 of the Patient Coordinator Assessment Form

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

Colon Screening Program

Patient Coordinator 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** _____

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

Assessment ☐ In Person ☐ By Phone

☐ Patient proceeding to colonoscopy

☐ Patient NOT proceeding to colonoscopy:

- ☐ Patient proceeding to colonoscopy **BUT** outside of the program
  - → ☐ Letter sent to GP
- ☐ Medically unfit
  - → ☐ Letter Sent to GP
- ☐ Family History does not meet colonoscopy eligibility
  - → ☐ Advise Patient to return to GP for FIT Screening
  - → ☐ Letter sent to GP
- ☐ Not due for colonoscopy screening/surveillance: _____ *(specify future date)*
- ☐ Patient declined → ☐ Letter sent to GP ☐ No further contact requested
- ☐ Unable to contact → ☐ Letter sent to GP ☐ Letter sent to patient
- ☐ Other *(specify)*: _____

☐ Colonoscopy deferred Until: _____ Reason _____

Teaching date/time: _____ Teaching Coordinator: _____

- ☐ Procedure explained
- ☐ Risks/complications discussed
- ☐ Consent process started
- ☐ Sedation discussed
- ☐ Transportation home discussed
- ☐ DM management for fasting explained
- ☐ Lab work ordered
- ☐ Advised to d/c iron 5-7 days ahead
- ☐ Contact pacemaker clinic
- ☐ Anticoagulants discussed

☐ Bowel prep explained *(specify)*: _____

☐ Appointment details provided: 1st available: _____ Booked: _____ *dd/mm/yy*

Ride to be provided by: _____ Responsible adult at home? ☐ No ☐ Yes

☐ Colonoscopist consult required: _____ ☐ HCP Referral: _____

Comments:

_____

_____

_____

Patient Coordinator Name _____ **Patient Coordinator Signature** _____ **Location** _____

Family History

1st degree relative CRC: ☐ No ☐ Yes

Relative	*Age at Diagnosis*

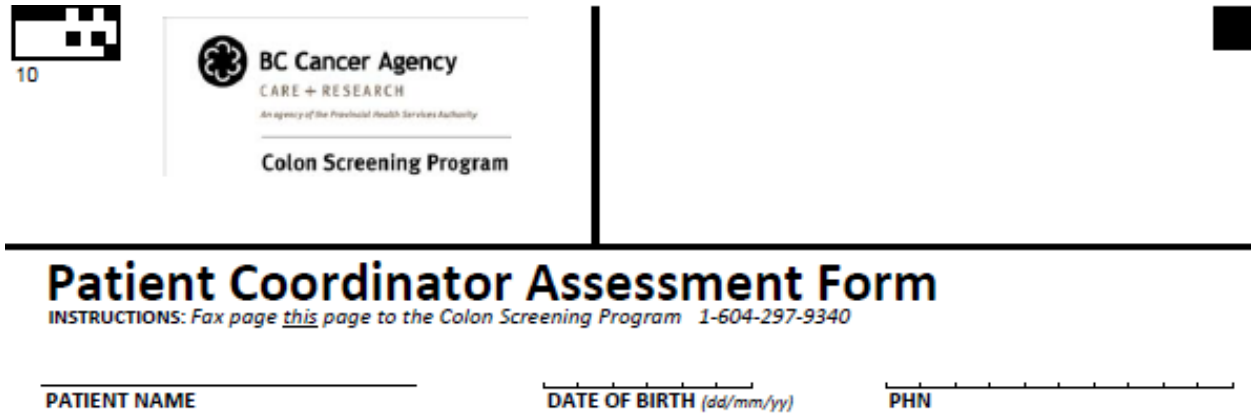
☐ More than three 1st degree Relatives

Any relatives with HNPCC connected Cancers?

☐ No

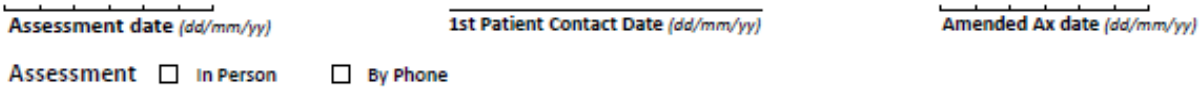
☐ Yes *(specify)*: _____

Patient Identifiers



Note: A minimum of 2 patient identifiers must be provided.	
Addressograph/Label	• Space for a hospital addressograph or hospital label is provided in the top right hand corner of the form. • If a legible hospital label is used, you do not need to enter the Patient Name, Date of Birth, and PHN data at the data fields below • If an addressograph is used, you need to fill out the Patient Name, Date of Birth, and PHN data at the data fields below, as addressographed information is often illegible on the faxed copy.
Patient Name	• Enter the patient's first name and surname
Date of Birth	• Enter the patient's date of birth, using the dd/mm/yy format
PHN	• Enter the patient's personal health number

Assessment and Contact Dates



Note: Assessment date, 1st patient contact date, and assessment method must be completed.	
Assessment Date	• Enter the date the assessment was completed, using the dd/mm/yy format • The assessment date cannot occur before the 1st patient contact date • The assessment date needs to be documented for ALL patients. i.e. if a referred patient is outside of the program target age range, please enter the date you determined that the patient would not be followed through the Colon Screening Program.
1st Patient Contact Date	• Enter the first date that the Patient Coordinator or Clerk

	attempted to contact the patient (i.e. the first date that the Patient Coordinator or Clerk leaves a message for, or speaks with the patient)
Amended Ax Date	• If there is any amended data documented on page 3 of the Patient Coordinator Assessment Form since you originally faxed Page 3 to the BCCA, please enter the date you amended the assessment form, using the dd/mm/yy format. • Additionally, please identify the amended data on the form by marking an asterisk or star next to the amended data. • Fax the amended Page 3 to BCCA.
Assessment	• Check the corresponding box to indicate if the assessment of the patient was done in person, or by phone.

Proceeding vs. Not Proceeding to Colonoscopy

☐ **Patient proceeding to colonoscopy**
☐ **Patient NOT proceeding to colonoscopy:**

Note: For ALL patients, one of the following two selections must be checked. Forms that are missing this information will be returned to the Patient Coordinator.	
Patient proceeding to colonoscopy	• Check this box for patients who are proceeding to colonoscopy as part of the Colon Screening Program
Patient NOT proceeding to colonoscopy	• Check this box for patients who are NOT proceeding to colonoscopy as part of the Colon Screening Program. • In addition to checking this "NOT proceeding" box, check one of the seven boxes in the section that follows on page 3 of the form, which best describes why the patient is not proceeding to colonoscopy as part of the Colon Screening Program.

Not Proceeding to Colonoscopy Reasons

☐ Patient proceeding to colonoscopy **BUT** outside of the program
→ ☐ Letter sent to GP
☐ Medically unfit
→ ☐ Letter Sent to GP
☐ Family History does not meet colonoscopy eligibility
→ ☐ Advise Patient to return to GP for FIT Screening
→ ☐ Letter sent to GP
☐ Not due for colonoscopy screening/surveillance: _____ *(specify future date)*
☐ Patient declined → ☐ Letter sent to GP ☐ No further contact requested
☐ Unable to contact → ☐ Letter sent to GP ☐ Letter sent to patient
☐ Other *(specify)*: _____

Note: Only one of the "Reason" selections below should be checked for patients who are not proceeding to colonoscopy. When multiple reasons have been selected, the form will be returned to the Patient Coordinator for clarification.	
Patient proceeding to colonoscopy <u>BUT</u> outside of the program	• A referred patient who is not being followed through the Colon Screening Program (i.e. patient is symptomatic; patient has already been referred to a specialist; patient is outside of age range). Please select the "Patient proceeding to colonoscopy BUT outside of the program" reason for these patients. • The Patient Coordinator or Clerk will send a letter to the GP. BCCA has a physician letter template available on the Patient Coordinator TeamSite. Use letter template *Physician Letter_Patient Not Proceeding* to communicate to the GP office why a patient is not proceeding to colonoscopy as part of the Colon Screening Program.
Medically unfit	• If a patient is medically unfit a physician must be involved in making this determination and may recommend alternative screening methods. • A patient may be inappropriate for colonoscopy indefinitely or this may be a transient situation, however, the Colon Screening Program will not be able to track these variations. • In addition to the consult from the colonoscopist, the Patient Coordinator or Clerk will use letter template *Physician Letter_Patient Not Proceeding* to communicate to the GP office why a patient is not proceeding to colonoscopy. • Patients are able to re-enter the program if their medical conditions changes and the patient still meets Colon Screening Program eligibility.
Family History does not meet colonoscopy eligibility	• The Patient Coordinator has determined that the patient does not have a first degree relative (parent, full-sibling or child) with colorectal cancer diagnosed under age 60, or more than 1 first degree relative diagnosed with colorectal cancer. • As these patients should be offered FIT test screening, the Patient Coordinator will advise the patient to return to their GP to discuss FIT testing. • The Patient Coordinator or Clerk will use letter template *Physician Letter_Patient Not Proceeding* to communicate to the GP office why a patient is not proceeding to colonoscopy.
Not due for colonoscopy screening/surveillance	• The Patient Coordinator may determine that a patient referred for a family history of colorectal cancer, or for personal history of adenomas, has had a colonoscopy in the last 5 years. Please document the future date that the patient is next due for screening. This date will be entered into our database to recall the patient for surveillance/screening at the appropriate interval.

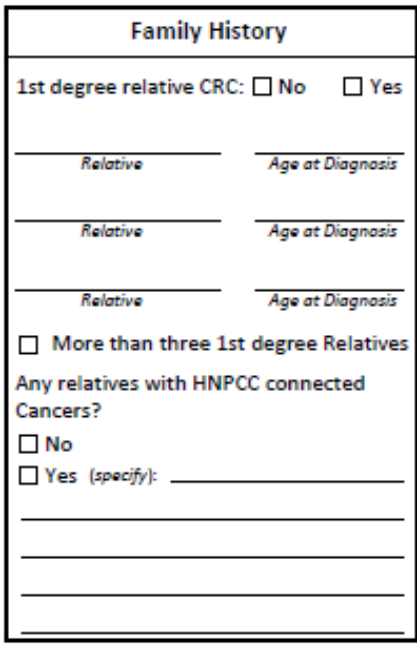
	• Patients with a family history of colorectal cancer and a normal FIT result will be referred to the Patient Coordinator for a surveillance colonoscopy on the 5th year after their previous scope. • Please note: patients who have had a colonoscopy in the past 5 years, and who now have an abnormal FIT result require follow up. • The Patient Coordinator or Clerk will use letter template *Physician Letter_Patient Not Proceeding* to communicate to the GP office why a patient is not proceeding to colonoscopy.
Patient declined	• If a patient declines, the Patient Coordinator or Clerk will use letter template *Physician Letter_Patient Not Proceeding* to communicate to the GP office why a patient is not proceeding to colonoscopy. • If a patient indicates that he/she would not like to be contacted for further screening, check the "no further contact requested" box to the right of the "declined" box. In our database, the patient's record will be marked as "Do not contact" and the patient will never be recalled for screening
Unable to contact	• The Patient Coordinator should make reasonable attempts to contact patients who have been referred for colonoscopy. • If the Patient Coordinator is unable to contact a patient for assessment or if a patient delays/misses colonoscopy appointments the Patient Coordinator should "close" the screening episode after one month of attempting to contact the patient. • The Patient Coordinator or Clerk must send a letter to both the patient and to the GP outlining that no further attempts will be made to contact the patient for colonoscopy. Use letter template *Patient Letter_Unable to Contact for Colonoscopy* to communicate with the patient and GP office.
Other	• Document any other reason, **not captured by the above reason selections,** for a patient not proceeding to colonoscopy. • The Patient Coordinator or Clerk will use letter template *Physician Letter_Patient Not Proceeding* to communicate to the GP office why a patient is not proceeding to colonoscopy.

Deferred Colonoscopy

☐ Colonoscopy deferred Until: _____ Reason _____

Colonoscopy deferred Until & Reason	• If the patient is deferring colonoscopy, document the date the procedure is deferred until and the reason for the deferral. • <u>If the date the colonoscopy is deferred until is ≤6 months:</u> As this deferral is short-term, the Patient Coordinator should keep the current screening episode "open" until the patient is available and the assessment form can be completed. Short term deferrals can be managed intra-office by the Patient Coordinator; the Patient Coordinator Assessment Form does not need to be faxed to BCCA. For these short term deferrals, please accurately document the 1st patient contact date, and document the 1st available colonoscopy date that would have applied had the patient been ready to proceed colonoscopy. • <u>If the date the colonoscopy is deferred until is >6 months:</u> As this deferral is long-term, the Patient Coordinator should complete the Patient Coordinator Assessment Form indicating that the patient is "Not proceeding to colonoscopy" citing the "Patient Declined" reason. In addition, document the colonoscopy deferred until date and the reason for deferral. Based on the deferred until date, BCCA will enter a future ACF message in the database. This will generate a new referral for the patient at the future date. The Patient Coordinator or Clerk should also send a letter to notify the GP. • Please note that the Patient Coordinator Assessment Form is only valid for a colonoscopy within 6 months, so a new Patient Coordinator Assessment Form will need to be completed when the patient is referred again.

Family History



Family History

1st degree relative CRC: ☐ No ☐ Yes

Relative _____ Age at Diagnosis _____

Relative _____ Age at Diagnosis _____

Relative _____ Age at Diagnosis _____

☐ More than three 1st degree Relatives

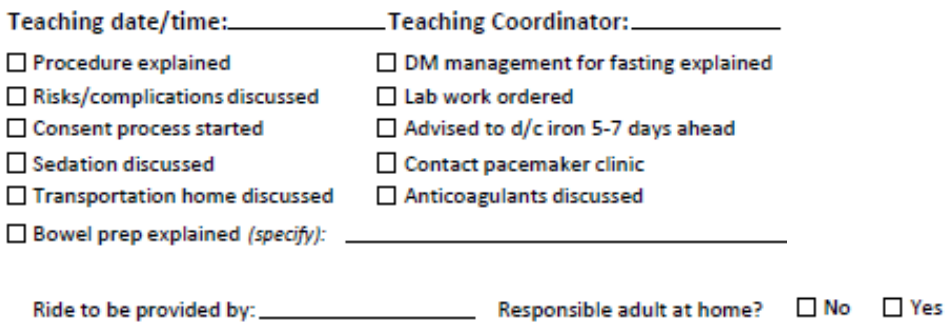
Any relatives with HNPCC connected Cancers?

☐ No

☐ Yes (specify): _____

1st degree relative CRC	• Indicate if the patient has any 1st degree relatives who were diagnosed with colorectal cancer. • If the patient has 1st degree relatives who were diagnosed with colorectal cancer, document these relatives (e.g. mother, brother) and their age at CRC diagnosis in the fields provided. Please document the youngest three relatives in order of their age at CRC diagnosis.
More than three 1st degree relatives	• Indicate if the patient has more than three 1st degree relatives who were diagnosed with colorectal cancer.
Any relatives with HNPCC connected cancers	• Indicate if the patient has any relatives with hereditary nonpolyposis colorectal cancer. Information regarding HNPCC/Lynch syndrome criteria can be found at http://www.screeningbc.ca/Hereditary/ForHealthProfessionals/Default.htm

Patient Teaching



Teaching date/time:_____ Teaching Coordinator:_____

☐ Procedure explained
☐ Risks/complications discussed
☐ Consent process started
☐ Sedation discussed
☐ Transportation home discussed
☐ Bowel prep explained (specify): _____
☐ DM management for fasting explained
☐ Lab work ordered
☐ Advised to d/c iron 5-7 days ahead
☐ Contact pacemaker clinic
☐ Anticoagulants discussed

Ride to be provided by: _____ Responsible adult at home? ☐ No ☐ Yes

Note: None of the teaching data is entered into the BCCA database	
Procedure explained	• Explain the procedure • Provide the patient with a copy of the BCCA "What is a Colonoscopy?" brochure, which is available on the www.screeningbc.ca website
Risks/complications discussed	• Discuss potential risks and complications of the procedure, following risks must be cited to the patient o Less than 5/1000 people will have a serious complication. This could include having a reaction to the medication used for sedation, developing an infection, bleeding from the colon or perforation of the colon (hole in the colon). o The risk of dying from colonoscopy is less than 1/14,000. o There is a risk of missing an abnormality; this occurs in less than 1/10 cases.
Consent process started	• Initiate the consent process
Sedation discussed	• Discuss sedation options for the procedure
Bowel prep explained	• Explain which bowel preparation the patient should use and when and how to begin the preparation
Transportation home discussed	• Ensure the patient will have transportation home for the day of the procedure and that the patient will not be left alone after the procedure.

Appointment Details

☐ Appointment details provided: 1st available: _____ Booked: ____/____/____
dd/mm/yy

Note: For patients proceeding to colonoscopy, both the 1st available date and the booked date are required.	
1st Available Date	• Using the dd/mm/yy format, document the 1st colonoscopy date that is available at the time of the assessment. This should be the colonoscopy date that is first offered to the patient. If the patient accepts this appointment, the "booked date" and the "1st available scope date" will be the same. • The 1st available date cannot occur after the booked date.
Booked Date	• Using the dd/mm/yy format, document the colonoscopy date that the patient is booked for. • If the patient prefers a different colonoscopist or a different date or time, book the patient into the date and time that meets their preferences. In this case, the "booked date" and the "1st available date" will be different.

Colonoscopist Consult and HCP Referral

☐ Colonoscopist consult required: _____ ☐ HCP Referral: _____

Colonoscopist consult required	• Document if the patient will be seen by a Colonoscopist for a consult prior to Colonoscopy.
HCP Referral	• Document if a patient is appropriate for referral to the Hereditary Cancer Program (HCP) for genetic counseling and testing (as appropriate). • Criteria for referral to the HCP is available on the *HCP Referral Form* or via the HCP website: http://www.screeningbc.ca/Hereditary/ForHealthProfessionals/ReferralProcess.htm#Referrals%20to%20the%20Hereditary%20Cancer%20Program

Comments, Patient Coordinator Identifiers and Location

Comments:

_____

_____

_____

_____ _____ _____

Patient Coordinator Name Patient Coordinator Signature Location

Comments	• Document any additional comments that you have related to your assessment of the patient.
Patient Coordinator Name and Patient Coordinator Signature	• Patient Coordinator Name and Patient Coordinator Signature must be documented on all Patient Coordinator Assessment Forms sent to BCCA
Location	• For all patients proceeding to colonoscopy, location must be documented. Document the hospital where the patient is booked to have the colonoscopy. • For patients not proceeding to colonoscopy, leave this field blank.