BC Cancer Agency

Colon Screening Program

Documentation Guide: Pre/Post Colonoscopy Unplanned Events Form

Version 1.0

Colon Screening Program

BC Cancer Agency

May 16, 2014

Table of Contents

Audience

This document contains descriptions of the data fields found on the Pre/Post Colonoscopy Unplanned Events Form. It will assist Patient Coordinators with filling out the data fields found on the Pre/Post Colonoscopy Unplanned Events Form.

Introduction

The Pre/Post Colonoscopy Unplanned Events Form is completed by the Patient Coordinator only for patients who experienced an unplanned event (complication) that required medical attention, either the day before their colonoscopy (e.g. bowel prep related complication), or during their 14 day post-colonoscopy period.

The purpose of the Pre/Post Colonoscopy Unplanned Events form is to provide information to the BC Cancer Agency (BCCA) Colon Screening Program regarding any unplanned events/complications the patient experienced either the day before their colonoscopy, or during their 14 day post-colonoscopy period.

Once complete, the Pre/Post Colonoscopy Unplanned Events form is faxed to the BCCA Colon Screening Program and the data is entered into the Colon Screening Program database. Accurate documentation of data and completeness of the data fields on the Pre/Post Colonoscopy Unplanned Events Form are important Patient Coordinator responsibilities. **Do not fax the Pre/Post Colonoscopy Unplanned Events form to the BCCA Colon Screening Program until all documentation is complete.** Pre/Post Colonoscopy Unplanned Events Forms with missing documentation or conflicting documentation will be returned to the Patient Coordinator for correction.

General Documentation Notes

- Write neatly, and legibly. Make sure that writing is dark enough that it will be visible on the fax received at BCCA.
- For patients who experienced an unplanned event (complication) that required medical attention, either the day before their colonoscopy (e.g. bowel prep related complications), or during their 14 day post-colonoscopy period, the Pre/Post Colonoscopy Unplanned Events form is filled out, **in addition** to the Follow-Up Recommendations Form.
- Please fax the Pre/Post Colonoscopy Unplanned Events form to BCCA at the same time that you fax BCCA the patient's Follow-Up Recommendations form.

Sample: Pre/Post Colonoscopy Unplanned Events Form

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

Colon Screening Program

Pre/Post Colonoscopy Unplanned Event

INSTRUCTIONS: *Fax a copy to the GP, the colonoscopist, and the Colon Screening Program (fax: 604-660-3645)*

PATIENT NAME	**DATE OF BIRTH**	**PHN**
GP	**COLONOSCOPIST**	**COLONOSCOPY DATE** *(dd/mm/yy)*
DATE OF ONSET OF SYMPTOMS	**SYMPTOMS ONGOING?** ☐ No ☐ Yes	**DATE OF RESOLUTION OF SYMPTOMS**

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
- ☐ Infection
- ☐ Death: Date of death: _____ Cause of death: _____
- ☐ Other: _____
- ☐ Perforation
- ☐ Respiratory
- ☐ Cardiac

Comments: _____

_____

Patient first obtained medical attention: _____ *(dd/mm/yy)*

☐ 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)*
- ☐ Other: _____
- ☐ 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:

Patient Identifiers


BC Cancer Agency
CARE + RESEARCH
Colon Screening Program

Pre/Post Colonoscopy Unplanned Event

INSTRUCTIONS: *Fax a copy to the GP, the colonoscopist, and the Colon Screening Program (fax: 604-660-3645)*

PATIENT NAME _____ DATE OF BIRTH _____ PHN _____

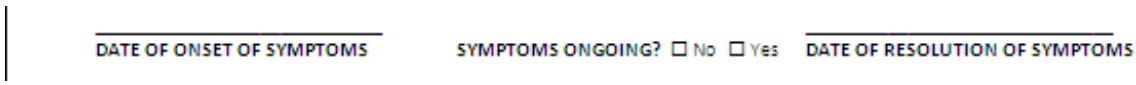
Note: A minimum of 2 patient identifiers must be provided.	
Addressograph/ Label	• Space for a hospital addressograph or hospital label is provided in the top right hand corner of the form. • If a legible hospital label is used, you do not need to enter the Patient Name, Date of Birth, and PHN data at 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

Colonoscopist Name and Colonoscopy Date

COLONOSCOPIST _____ COLONOSCOPY DATE *(dd/mm/yy)* _____

Note: Colonoscopist Name and Colonoscopy Date must be provided.	
Colonoscopist	• Enter the name of the colonoscopist who performed the colonoscopy
Colonoscopy Date	• Enter the date the colonoscopy was performed, using the dd/mm/yy format

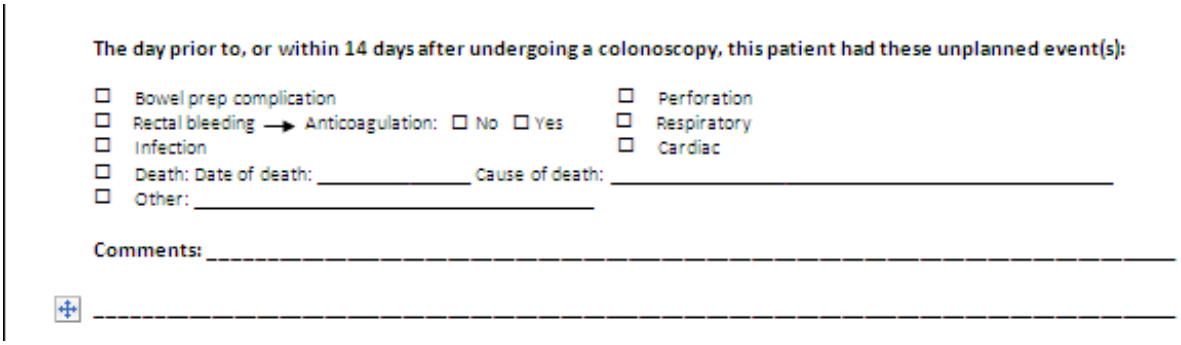
Symptoms


DATE OF ONSET OF SYMPTOMS _____ SYMPTOMS ONGOING? ☐ No ☐ Yes DATE OF RESOLUTION OF SYMPTOMS _____

Note: Date of onset of symptoms and symptoms ongoing must be completed.	
Date of Onset of Symptoms	• Enter the date that the patient began experiencing symptoms, using the dd/mm/yy format

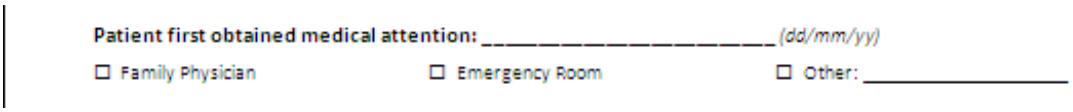
Symptoms Ongoing	• Select one of the No or Yes check boxes, to indicate if the patient was still experiencing symptoms at the time you did your follow-up with him/her.
Date of Resolution of Symptoms	• If the patient is no longer experiencing symptoms, enter the date the symptoms resolved, in dd/mm/yy format.

Unplanned Events



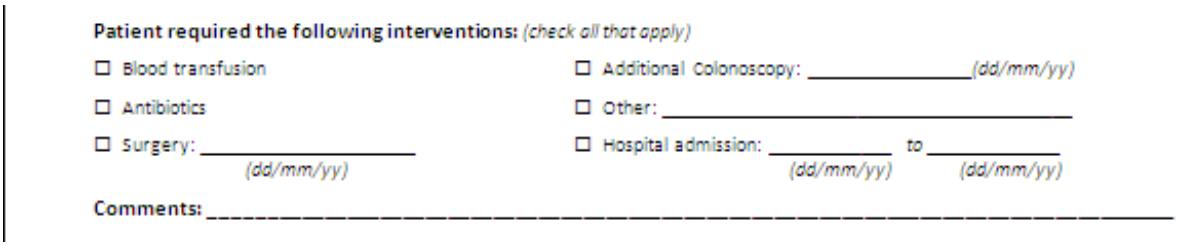
Note: Unplanned Events must be completed for patients who experienced an unplanned event (complication) that required medical attention, either the day before their colonoscopy (e.g. bowel prep related complications), or during their 14 day post-colonoscopy period. If applicable, multiple unplanned events may be selected.	
Bowel Prep Complication	• Select this check box if the patient experienced a bowel prep complication that required medical attention.
Perforation	• Select this check box if the patient experienced a perforation.
Rectal Bleeding	• Select this check box if the patient experienced rectal bleeding that required medical attention. • Select one of the No or Yes check boxes, to indicate if the patient takes anticoagulants or antiplatelet drugs.
Respiratory	• Select this check box if the patient experienced a respiratory complication that required medical attention.
Infection	• Select this check box if the patient experienced an infection that required medical attention
Cardiac	• Select this check box if the patient experienced a cardiac complication that required medical attention.
Death	• Select this check box if the patient died. • At the date of death field, enter the date that the patient died, using the dd/mm/yy format. • At the cause of death field, document the cause of death
Other	• Select this check box if the patient experienced a complication, not already covered in the unplanned event list that required medical attention. • At the specify field, provide a description of the other unplanned event/complication.
Comments	• Document any additional comments that you are relevant to the unplanned event the patient experienced.

Medical Attention



Note: The date the patient first obtained medical attention for the unplanned event, and whom/where they obtained medical attention from must be documented.	
Date the Patient First obtained Medical Attention	• Enter the date that the patient first obtained medical attention for the unplanned event/complication, using the dd/mm/yy format.
Medical Attention obtained from	• Select one of the Family Physician, Emergency Room, or Other check boxes, to indicate whom/where the patient obtained medical attention from. • If the Other check box is selected, document the name of the professional/facility the patient sought medical attention from.

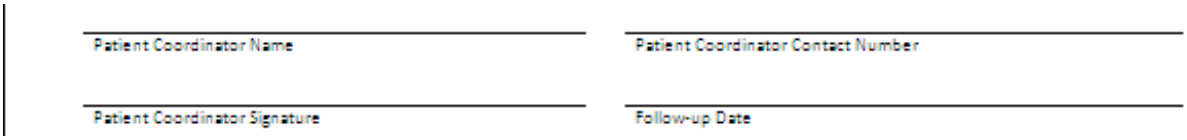
Interventions



Note: If applicable, multiple interventions may be selected.	
Blood Transfusion	• Select this check box if the patient received a blood transfusion.
Additional Colonoscopy	• Select this check box if the patient needed to have an additional colonoscopy performed. • At the date field, enter the date the additional colonoscopy was performed, using the dd/mm/yy format.
Antibiotics	• Select this check box if the patient received antibiotic therapy.
Other	• Select this check box if the patient received an intervention, not already covered in the interventions listed. • Provide a description of the other intervention.
Surgery	• Select this check box if the patient needed to have surgery. • At the date field, enter the date the surgery was performed, using the dd/mm/yy format
Hospital Admission	• Select this check box if the patient needed to be admitted to hospital. • At the first date field, enter the date the patient was admitted to hospital, using the dd/mm/yy format

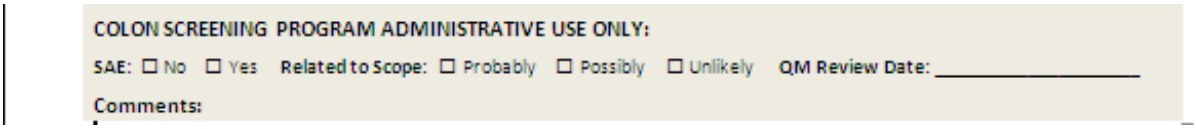
	• At the second date field, enter the date the patient was discharged from hospital, using the dd/mm/yy format. If the patient remains in hospital, leave the second date field blank.
Comments	• Document any additional comments that you feel are relevant to the interventions the patient received.

Patient Coordinator Identifiers



Patient Coordinator Name and Patient Coordinator Signature	• Patient Coordinator Name and Patient Coordinator Signature must be documented on all Pre/Post Colonoscopy Unplanned Events forms faxed to BCCA
Follow-Up Date	• Enter the date of follow up, using the dd/mm/yy format.

Colon Screening Program Administrative Use



The fields at the bottom of the Pre/Post Colonoscopy Unplanned Event form are for BCCA Colon Screening Program administrative use only. Do not document at these fields.