BC CANCER COLON SCREENING
Provincial Health Services Authority

COLONOSCOPY REPORTING FORM

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

PRESS FIRMLY TO ENSURE LEGIBILITY FOR MULTIPLE COPIES
FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297 9340
GREY SECTIONS TO BE COMPLETED AS REQUIRED

EXAM DATE (DD-MMM-YYYY) | START TIME (HRS) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X/U)

FACILITY NAME | AMENDED DATE (DD-MMM-YYYY) | PHN | DATE OF BIRTH (DD-MMM-YYYY)

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

Reason Colonoscopy did not occur (select one): ☐ No Show for Colonoscopy ☐ Medically unfit day of procedure

1. BOWEL 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 → **Photo documentation?** ☐ No ☐ Yes
☐ 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:

	Specimen Type	Location	Size(mm) ≤5	Size(mm) 6-9	Size(mm) 10-19	Size(mm) ≥20	Morphology	Primary Removal Mode	Submucosal Injection (Y/N)	Piecemeal (Y/N)	Complete Removal (Y/N/U)	Complete Retrieval (Y/N/U)	Specimen Sent (Y/N/#)	Time	Initials
Example	**P**	**T**		✓			**P**	**HS**	**Y**	**Y**	**Y**	**Y**	**Y**	**14:00**	**AB**
1/A															
2/B															
3/C															
4/D															
5/E															

6. ☐ Additional specimens recorded on Page 2

7. ☐ Repeat Colonoscopy Required
COMPLETE COLONOSCOPY REPORTING FORM FOR NEXT SCOPE

Specimen Type
B = biopsies
P = polypectomy

Y = yes N = no
U = uncertain

Location
A = ascending colon
C = cecum D = descending
I = ileum L = left colon
O = other/random
R = rectum S = sigmoid
T = transverse colon

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

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

MD NAME: _____ **SIGNATURE:** _____ **RN NAME:** _____ **SIGNATURE:** _____

SEND COPIES OF PATHOLOGY REPORT TO:

1. BC Cancer Colon Screening
   Fax#: 1 (604) 297 9340
2. _____ Primary Provider (Name & MSC#)
3. _____ Other (Name & MSC#)
4. _____ Other (Name & MSC#)

Specimen tracking required by facility?
☐ No ☐ Yes →

Number of samples sent to collection area: ____ INITIALS _____ DATE: _____
Number of samples transported to lab: ____ INITIALS _____ DATE: _____
Number of samples 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

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