DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

BC CANCER COLON SCREENING
Provincial Health Services Authority

COLONOSCOPY REPORTING FORM PAGE 2

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 (YYYYMMDD) | START TIME (HRS) | PHN | DATE OF BIRTH (YYYYMMDD)

FACILITY NAME | AMENDED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (M/F/X)

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

Reason for Colonoscopy (select one):
☐ FIT ☐ Family History ☐ Surveillance ☐ Deviation

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

	Specimen Type	Location	Size(mm)				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
			≤5	6-9	10-19	≥20									
Example	**P**	**T**			✓		**P**	**HS**	**Y**	**Y**	**Y**	**Y**	**Y**	**14:00**	**AB**
6/F															
7/G															
8/H															
9/I															
10/J															
11/K															
12/L															
13/M															
14/N															
15/O															
16/P															
17/Q															
18/R															

Y = yes N = no
U = uncertain

Specimen Type
B = biopsies
P = polypectomy

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:** _____

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

20320

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CHART COPY | FILE IN CHART

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HEALTH AUTHORITY COPY

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RN NAME: _____ **SIGNATURE:** _____

COLONOSCOPIST COPY | FOR YOUR RECORDS

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Colonoscopy Reporting Form Instructions for Completion of Page 2

Note:* *Optional information is in italics

PLEASE press firmly to ensure that all four copies of this form are legible. FAX the top copy.

Patient Identifiers: A label can be used if legible and affixed in the upper right corner, otherwise complete all required fields.

Specimen Table: (as described by column moving from left to right of the table)

- **Specimen Container:** Uniquely identified as either "1" or "A", etc. and adapts to lab specimen container sequencing based on lab or HA requirements.
- **Specimen Type:** Requires a single letter from the legend and is either a (B) biopsy or a (P) polypectomy.

NOTE: Random biopsies can be placed together in the same specimen container however each polyp must be placed in an individual specimen container. Choose (P) for all polyps even if removed using biopsy forceps.

- **Location:** Requires a 1 letter code entry referenced under "Location" in the legend. Choose "Other" for random biopsies.
- **Size:** Requires one check mark only in one of the four columns based on size.
- **Morphology:** Requires a 1 letter code entry referenced under "Morphology" in the legend. Choose "Other" for random biopsies.
- **Primary Removal Mode:** Requires a 2 letter code entry referenced under "Removal Mode" in the legend.
- **Submucosal Injection:** Requires a "Y" for Yes, or "N" for No entry as per the legend.
- **Piecemeal:** Requires a "Y" for Yes, or "N" for No entry as per the legend.
- **Complete Removal:** Requires a "Y" for Yes, "N" for No or "U" for Uncertain entry as per the legend.
- **Complete Retrieval:** Requires a "Y" for Yes, "N" for No or "U" for Uncertain entry as per the legend.
- **Specimen Sent:** Requires a "Y" for Yes, "N" for No as per the legend *(# is the number of pieces and is optional based on lab or HA requirements).*
- ***Time:*** *Optional based on individual lab or HA requirements.*
- ***Initials:*** *Optional based on individual lab or HA requirements.*

Signature: MD Name requires the Colonoscopist to print and sign their name indicating form accuracy and completion.

Send Copies of Pathology Report To:

1. This copy is for BC Cancer Colon Screening and is required to ensure complete screening records are maintained.
2. List the PCP Name and MSC# to ensure that a copy of the pathology report is sent to the primary care provider
3. & 4. Document the name and MSP/billing number of any other providers that should receive a copy of the pathology report

Chain of Custody Section: *If applicable and required by HA, document the number of samples (specimen containers) sent, transported, and received by the lab, including the initials of the person and the date for each one of these three aspects.*