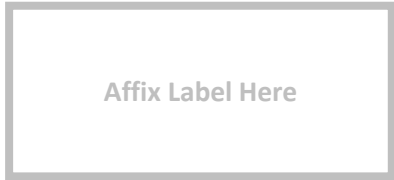


Assessment Form



1st CONTACTED DATE (YYYYMMDD)	COMPLETED DATE (YYYYMMDD)	PATIENT NAME LAST	PATIENT NAME FIRST	
HEALTH AUTHORITY SERVICE CENTRE	AMENDED DATE (YYYYMMDD)	PHN	DATE OF BIRTH (YYYYMMDD)	SEX (F/M/X)
		PRIMARY CARE PROVIDER (MSC)	PRIMARY PROVIDER LAST, FIRST	

Alerts for Colonoscopy:

<input type="checkbox"/> Anticoagulation	<input type="checkbox"/> Iron tablets (<i>stop 7 days</i>)	<input type="checkbox"/> Significant co-morbid illness
<input type="checkbox"/> Antiplatelet agent	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Allergies/sensitivities
<input type="checkbox"/> Defibrillator/Pacemaker	<input type="checkbox"/> COPD	<input type="checkbox"/> No blood transfusions
<input type="checkbox"/> Diabetic insulin/tablets	<input type="checkbox"/> CHF	<input type="checkbox"/> Renal insufficiency/dialysis
<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Contact Precaution (specify): _____	

Comments:

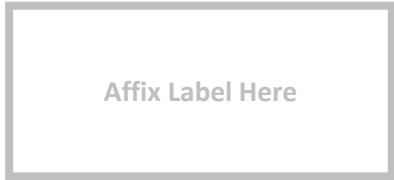
Reason for Colonoscopy Assessment: + FIT + Family History Surveillance/Deviation

Medication	Dose	Freq.	Medication	Dose	Freq.	Medication	Dose	Freq.

Allergies: NKA

Symptoms (within last 6 months)	No	Yes	Comments
BM Frequency (<i>specify</i>)			
Recent changes in bowel habits			
Diarrhea			
Constipation			
Rectal bleeding			
Bowel urgency			
Unexplained weight loss			
Abdominal pain			
Upper GI Symptoms (<i>eg. N&V, swallowing difficulties, GERD</i>)			

Comments:



PATIENT NAME LAST

PATIENT NAME FIRST

PHN

DATE OF BIRTH (YYYYMMDD)

Medical History	No	Yes	Comments
Gastrointestinal (eg. Ulcers, Barrets, Hiatus hernia, Diverticular disease)			
Hx colonoscopy or flexible sigmoidoscopy			
Surgery (eg. Abdominal and other)			
Cardiac (eg. A. Fib, Pacemaker, ICD, CHF)			
Hypertension			
Respiratory (eg. Sleep apnea, asthma, COPD)			
Liver			
Renal (eg. document eGFR <60ml/min, creatinine >100umol/L, if known)			
Diabetes (eg. Type 1/2, Insulin, oral Hypoglycaemic)			
Glaucoma			
Neurological (e.g. Epilepsy, Stroke, MS, Parkinson's, Alzheimer's, dementia, etc.)			
Cancer			
Bleeding disorder			
Blood transfusion concerns (eg. Jehovah's witness)			
Problems with sedation or anaesthesia			

Comments / Other Medical Concerns:

Patient lives: Alone With (specify): _____

Do you consider yourself to have a disability? No Yes

Mental health difficulty Dyslexia Mobility Progressive disability (eg MS) Learning disability

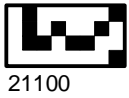
Blind/partially blind Deaf/HOH Other (specify): _____

Smoker: No Yes #/day: _____ Quit date (approximate): _____

EtOH: No Yes units/week: _____

Recreational or illicit Drug Use: No Yes Substance: _____ Frequency: _____

Height (cm): _____ **Weight (kg):** _____ **BMI:** _____



21100



Assessment Form

NOT REQUIRED TO FAX TO BC CANCER

1st CONTACTED DATE (YYYYMMDD)	COMPLETED DATE (YYYYMMDD)	PATIENT NAME LAST	PATIENT NAME FIRST	
HEALTH AUTHORITY SERVICE CENTRE	AMENDED DATE (YYYYMMDD)	PHN	DATE OF BIRTH (YYYYMMDD)	SEX (F/M/X)
		PRIMARY CARE PROVIDER (MSC)	PRIMARY PROVIDER LAST, FIRST	

Assessment In Person By Phone Patient Not Contacted

FOR ALL PATIENTS: Family History

FDR diagnosed CRC: No Yes More than 3 FDR **Any relatives with HNPCC connected Cancers?** No Yes

Relative:	Age at	Diagnosis	Specify:
Relative:	Age at	Diagnosis	
Relative:	Age at	Diagnosis	

Patient proceeding to colonoscopy as part of the Colon Screening Program

1st available date (YYYYMMDD) Booked date (YYYYMMDD) Procedure Location

Patient teaching <input type="checkbox"/> Appointment details provided <input type="checkbox"/> Procedure explained <input type="checkbox"/> Bowel prep explained <input type="checkbox"/> Sedation options discussed <input type="checkbox"/> Risks/complications discussed <input type="checkbox"/> Transportation home discussed, ride to be provided by: _____	Patient instructions (if applicable) <input type="checkbox"/> Advised to discontinue iron 7 days prior <input type="checkbox"/> Diabetics - patient aware to consult w/ GP or specialist regarding fasting & medications <input type="checkbox"/> Antithrombotics - patient aware to discuss with GP/specialist when to stop medications <input type="checkbox"/> Pacemaker - ensure hospital protocols are met for these patients	Teaching date/time: _____ Teaching Coordinator: _____
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Patient NOT proceeding to colonoscopy as part of the Colon Screening Program (please specify):

Communication provided to GP/NP <input type="checkbox"/> Crohn's or ulcerative colitis <input type="checkbox"/> Colorectal cancer history <input type="checkbox"/> Symptomatic, GP/NP to refer to specialist <input type="checkbox"/> Outside the target age <input type="checkbox"/> Medically unfit <input type="checkbox"/> Family history does not meet colonoscopy eligibility	<input type="checkbox"/> Not due for colonoscopy screening/surveillance/follow-up: _____ (specify future date) (YYYYMM) <input type="checkbox"/> FIT <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Patient declined <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Other (specify): _____
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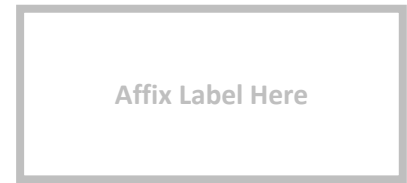
Patient is not proceeding at this time but a future recall is required - future date (YYYYMM): _____ FIT Colonoscopy

Colonoscopist consult required: _____ HCP Referral: _____

Comments: _____

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





PATIENT NAME LAST

PATIENT NAME FIRST

PHN

DATE OF BIRTH (YYYYMMDD)

Date	Notes