BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

Affix Label Here

1st CONTACTED DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST

NHA WEST TWO

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:

- ☐ Anticoagulation
- ☐ Antiplatelet agent
- ☐ Defibrillator/Pacemaker
- ☐ Diabetic insulin/tablets
- ☐ Sleep Apnea
- ☐ Iron tablets *(stop 7 days)*
- ☐ Glaucoma
- ☐ COPD
- ☐ CHF
- ☐ Contact Precaution (specify): _____
- ☐ Significant co-morbid illness
- ☐ Allergies/sensitivities
- ☐ No blood transfusions
- ☐ Renal insufficiency/dialysis

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 *(specify)*			
Recent changes in bowel habits			
Diarrhea			
Constipation			
Rectal bleeding			
Bowel urgency			
Unexplained weight loss			
Abdominal pain			
Upper GI Symptoms *(eg. N&V, swallowing difficulties, GERD)*			

Comments:

BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

Affix Label Here

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

BC CANCER COLON SCREENING
Provincial Health Services Authority

Affix Label Here

Assessment Form

NOT REQUIRED TO FAX TO BC CANCER

1st CONTACTED DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST

NHA WEST TWO
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

- ☐ Appointment details provided
- ☐ Procedure explained
- ☐ Bowel prep explained
- ☐ Sedation options discussed
- ☐ Risks/complications discussed
- ☐ Transportation home discussed, ride to be provided by: _____

Patient instructions (if applicable)

- ☐ Advised to discontinue iron 7 days prior
- ☐ Diabetics - patient aware to consult w/ GP or specialist regarding fasting & medications
- ☐ Antithrombotics - patient aware to discuss with GP/specialist when to stop medications
- ☐ Pacemaker - ensure hospital protocols are met for these patients

Teaching date/time: _____

Teaching Coordinator: _____

☐ **Patient NOT proceeding to colonoscopy as part of the Colon Screening Program** *(please specify):*

Communication provided to GP/NP

- ☐ Crohn's or ulcerative colitis
- ☐ Colorectal cancer history
- ☐ Symptomatic, GP/NP to refer to specialist
- ☐ Outside the target age
- ☐ Medically unfit
- ☐ Family history does not meet colonoscopy eligibility
- ☐ Not due for colonoscopy screening/surveillance/follow-up: _____ (*specify future date*) (YYYYMM) ☐ FIT ☐ Colonoscopy
- ☐ Patient declined
- ☐ Unable to contact patient
- ☐ Other (specify): _____

☐ 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**

BC CANCER COLON SCREENING
Provincial Health Services Authority

Assessment Form

Affix Label Here

PATIENT NAME LAST	PATIENT NAME FIRST	PHN	DATE OF BIRTH (YYYYMMDD)

Date	Notes

801- 686 West Broadway | Vancouver, BC | V5Z 1G1 ☎ | 1-877-70-COLON | www.screeningbc.ca