BC CANCER COLON SCREENING
Provincial Health Services Authority

PRE/POST COLONOSCOPY UNPLANNED EVENT

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

FAX THIS PAGE TO COLON SCREENING PROGRAM: 1 (604) 297-9340

EXAM DATE: COLONOSCOPY (DD-MMM-YYYY) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X/U)

FOLLOW UP DATE (DD-MMM-YYYY) | AMENDED DATE (DD-MMM-YYYY) | PHN | DATE OF BIRTH (DD-MMM-YYYY)

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST

DATE OF ONSET SYMPTOMS (DD-MMM-YYYY) **Symptoms ongoing?** ○ No ○ Yes DATE OF RESOLUTION (DD-MMM-YYYY)

The day prior to, day of, or within 14 days after undergoing a colonoscopy, this patient had these uplanned event(s):

- ☐ Bowel prep complication
- ☐ Rectal bleeding → Antithrombotic: ○ No ○ Yes
- ☐ Infection
- ☐ Death: _____ (DD-MMM-YYYY)
  - Cause of death: _____
- ☐ Perforation
- ☐ Respiratory
- ☐ Cardiac
- ☐ Other: _____

Comments: _____

Patient first obtained medical attention: _____ (DD-MMM-YYYY)

☐ Family Physician ☐ Emergency Room ☐ Other: _____

Patient required the following interventions: *(check all that apply)*

- ☐ Blood transfusion
- ☐ Antibiotics
- ☐ Surgery: _____ (DD-MMM-YYYY)
- ☐ Additional Colonoscopy: _____ (DD-MMM-YYYY)
- ☐ Other: _____
- ☐ Hospital admission: _____ (DD-MMM-YYYY) to _____ (DD-MMM-YYYY)

Comments: _____

Patient Coordinator Name | Patient Coordinator Signature

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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