BC CANCER COLON SCREENING
Provincial Health Services Authority

Documentation Guide:

Referral Update Form

Contents

Audience

The Health Authority Staff responsible for completing pre-colonoscopy assessment for each client through the Colon Screening Program.

Introduction

Referral Update Form instructions are provided in this document to ensure standardization and promote consistent data collection for patients across B.C. The documentation provided on the Referral Update Form is used by BC Cancer to support patients being assessed by the appropriate Health Authority referral service centre and to end a screening cycle for patients who will not go on at this time to have colonoscopy. The data on these forms is used to report on program indicators including Health Authority Quality Reports and is used as a source for recalling patients within the program.

Once complete, fax the Referral Update Form the BC Cancer Colon Screening Program and the data will be entered into the Colon Screening Program database to update the patient's record. This ensures that, where appropriate, the patient is recalled by the Colon Screening Program at the next recommended re-screening/surveillance interval.

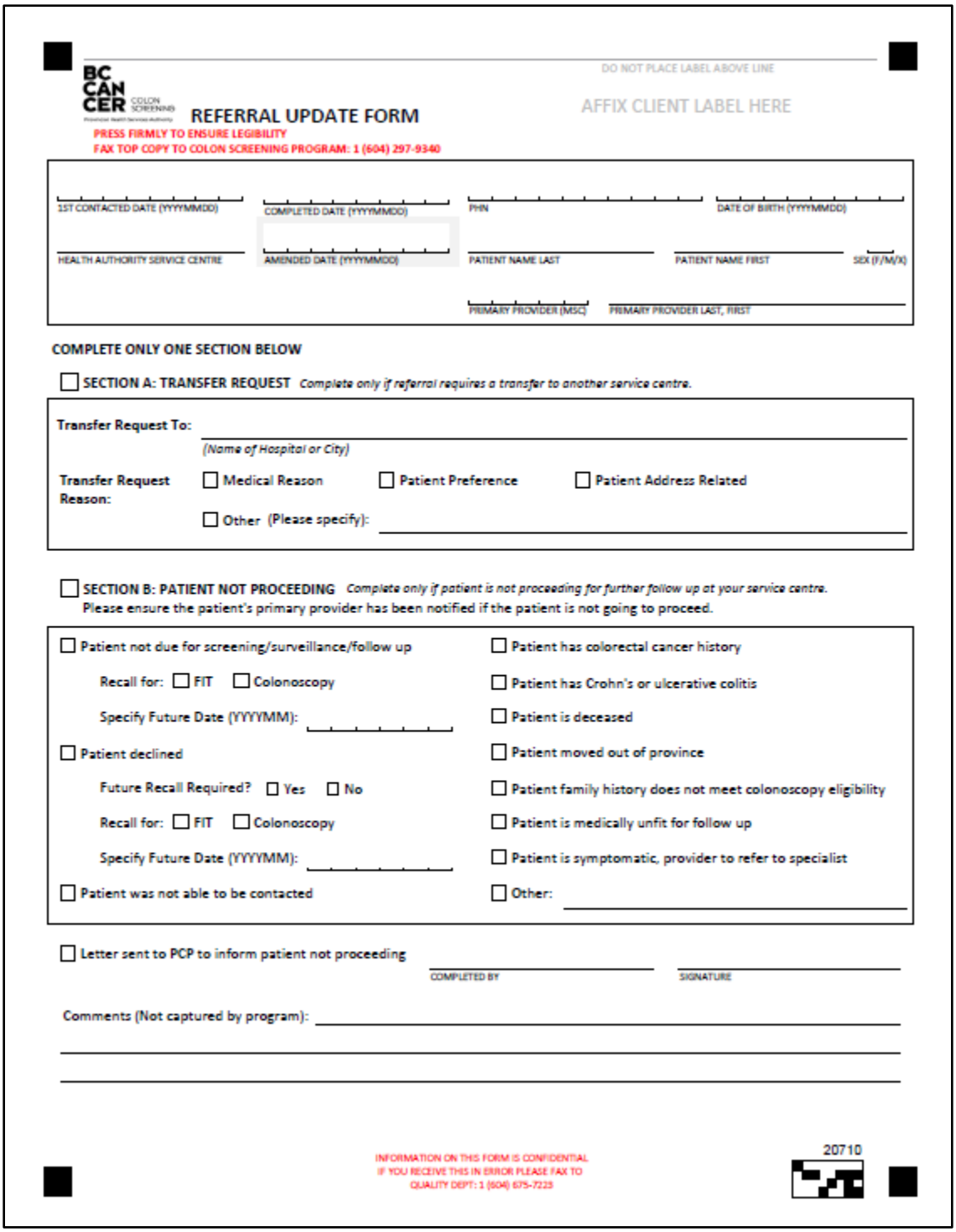
Please do not fax the Referral Update Form to the BC Cancer Colon Screening Program until documentation is complete**.** Referral Update Forms with missing documentation or conflicting documentation will be returned for correction.

General Instructions

- Write neatly and legibly.
- Fax completed colon forms to (604) 297-9340.

Fields described below that are italicized will not be used by the Colon Screening Program and are for local use/clinical documentation as required.

Sample of Referral Update Form



DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

REFERRAL UPDATE FORM

PRESS FIRMLY TO ENSURE LEGIBILITY

FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297-9340

1ST CONTACTED DATE (YYYYMMDD) | COMPLETED DATE (YYYYMMDD) | PHN | DATE OF BIRTH (YYYYMMDD)

HEALTH AUTHORITY SERVICE CENTRE | AMENDED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (F/M/X)

PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

COMPLETE ONLY ONE SECTION BELOW

☐ **SECTION A: TRANSFER REQUEST** *Complete only if referral requires a transfer to another service centre.*

Transfer Request To: _____

(Name of Hospital or City)

Transfer Request Reason: ☐ Medical Reason ☐ Patient Preference ☐ Patient Address Related

☐ Other (Please specify): _____

☐ **SECTION B: PATIENT NOT PROCEEDING** *Complete only if patient is not proceeding for further follow up at your service centre.*

Please ensure the patient's primary provider has been notified if the patient is not going to proceed.

☐ Patient not due for screening/surveillance/follow up

Recall for: ☐ FIT ☐ Colonoscopy

Specify Future Date (YYYYMM): _____

☐ Patient declined

Future Recall Required? ☐ Yes ☐ No

Recall for: ☐ FIT ☐ Colonoscopy

Specify Future Date (YYYYMM): _____

☐ Patient was not able to be contacted

☐ Patient has colorectal cancer history

☐ Patient has Crohn's or ulcerative colitis

☐ Patient is deceased

☐ Patient moved out of province

☐ Patient family history does not meet colonoscopy eligibility

☐ Patient is medically unfit for follow up

☐ Patient is symptomatic, provider to refer to specialist

☐ Other: _____

☐ Letter sent to PCP to inform patient not proceeding

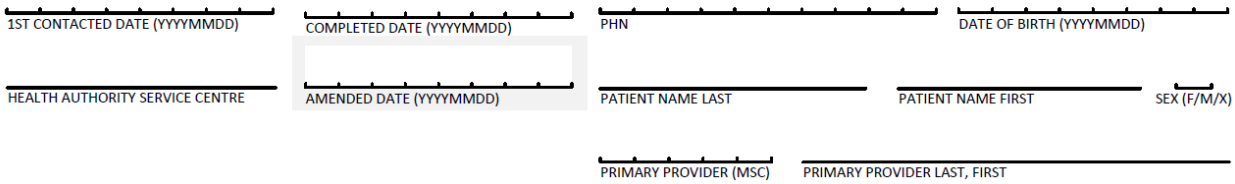
COMPLETED BY | SIGNATURE

Comments (Not captured by program): _____

INFORMATION ON THIS FORM IS CONFIDENTIAL
IF YOU RECEIVE THIS IN ERROR PLEASE FAX TO
QUALITY DEPT: 1 (604) 675-7223

20710

Patient/Provider Identifiers



Patient Label REQUIRED FIELD	• Space for a hospital addressograph or hospital label is provided in the top right hand corner of the form. • If a legible hospital label is used, you do NOT need to enter the Patient Name, Date of Birth, and PHN data into the data fields below. • If an addressograph is used, you need to fill out the Patient Name, Date of Birth, and PHN data in the data fields below it, as addressograph information is often illegible on the faxed copy.
1ST Contacted Date	• Enter the date the patient was first attempted to be contacted for pre-colonoscopy assessment in YYYYMMDD format.
Completed Date REQUIRED FIELD	• Enter the date the form was completed and sent to the Colon Screening Program in YYYYMMDD format. If unable to contact patient, this date may be the last date that was used to attempt to contact patient.
Health Authority Service Centre REQUIRED FIELD	• Enter the Health Authority Referral Service Centre for the centre that has received the referral and will complete this form.
Amended Date	• If you previously sent in a Referral Update Form on a patient and would like to change something on the form, complete the amended date on the form and clearly indicate the changes you are making. • Use the YYYYMMDD format for the amended date. • If you are not amending a form, leave this blank.
PHN REQUIRED FIELD	• Indicate the patient's personal health number. • If the patient does not have a personal health number, indicate the alternate health number.
Date of Birth REQUIRED FIELD	• Indicate the patient's date of birth using the YYYYMMDD format.
Patient Name Last REQUIRED FIELD	• Indicate the patient's last name in block letters.
Patient Name First REQUIRED FIELD	• Indicate the patient's first name in block letters.
Sex REQUIRED FIELD	• Indicate sex of patient either F, M or X.
Primary Provider (MSC) REQUIRED FIELD	• Indicate the primary provider's 5 digit MSC number.
Primary Provider Name Last, First REQUIRED FIELD	• Indicate the primary provider's last and first name in block letters. This is the provider who will be sent any further correspondence from the Colon Screening Program on this patient.

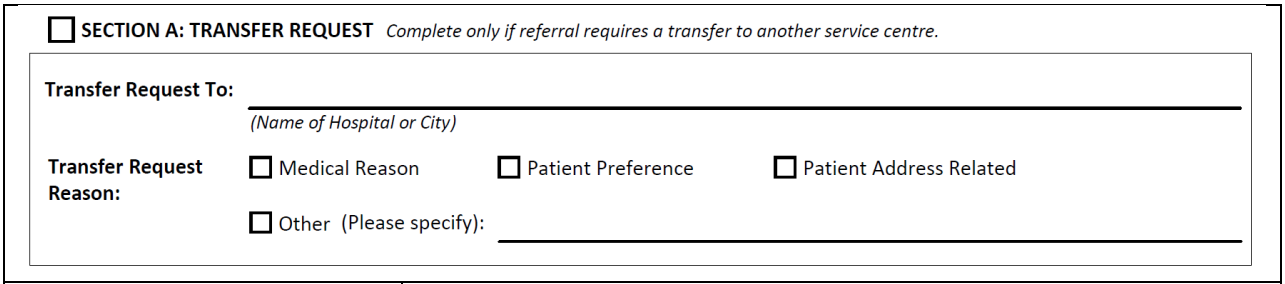
List of Health Authority Referral Service Centre

Health Authority Service Centre	City
Fraser East	Abbotsford, Chilliwack, Mission
Fraser North	Burnaby, Coquitlam, New Westminster, Port Moody
Fraser South	Delta, White Rock, Surrey, Langley, Aldergrove
Interior Central KGH	Kelowna
Interior Central PRH	Penticton
Interior East	Creston, East Kootenay, Elk Valley, Golden
Interior Kootenay Boundary	Nelson, Trail

Interior North	Williams Lake
Interior Revelstoke	Revelstoke
Interior Vernon	Vernon
Interior West	Kamloops
Vancouver One	Richmond
Vancouver Two	Vancouver
Vancouver Three	North Vancouver
Vancouver Four	Squamish
Vancouver Five	Sechelt
Vancouver Six	Powell River
Island Centre North	Nanaimo
Island Victoria	Victoria

Section A: Transfer Request

This section should **ONLY** be completed if the patient is to be transferred from one Health Authority Referral Service Centre to another, even if the new Referral Service Centre will be within the same Health Authority. The transfer request will ensure the referral, and subsequent letters, can be correctly routed to the correct Health Authority Referral Service Centre for the patient.


☐ **SECTION A: TRANSFER REQUEST** *Complete only if referral requires a transfer to another service centre.*

Transfer Request To: _____
(Name of Hospital or City)

Transfer Request Reason: ☐ Medical Reason ☐ Patient Preference ☐ Patient Address Related

☐ Other (Please specify): _____

Section A: Transfer Request	• Select this option if completing this section **ONLY** when the patient should be transferred to a different Health Authority Referral Service Centre.
Transfer Request To	• Enter the Hospital, City, or Referral Service Centre the patient will be transferred to where the patient should be contacted for pre-colonoscopy assessment. • This must **not** be the same Referral Service Centre indicated in the Patient/Provider Identifiers. • *Facilitated referrals are not inclusive of Northern Health Authority. Patients unable to have colonoscopy within the participating health authorities will require health authority staff to inform Primary Care Provider to refer to a specialist in NHA. Select “Other” in Section B and indicate reason.
Transfer Request Reason	• Indicate the reason for the patient transfer. • Indicate “Medical Reason” for situations where the patient required a different provider or facility for their procedure (e.g. medically complex patient, large polyp to remove, etc.) • Indicate “Patient Preference” if the patient is requesting their procedure at another facility (e.g. colonoscopist preference, preferred facility location, etc.) • Indicate “Patient Address Related” to capture instances when the patient has moved to another area of the province and the address on file was out of date or if the patients address was inappropriately linked to the Service Centre in receipt of the referral. • Only indicate “Other” if the above three options do not apply. Describe the reason for the transfer.

Section B: Patient Not Proceeding

This section should **ONLY** be completed to advise the Colon Screening Program that the patient is not proceeding to colonoscopy. In general, indicate the primary reason the patient is not proceeding. At times, it may be helpful to provide multiple reasons. If multiple reasons are indicated, each reason will be captured.

☐ **SECTION B: PATIENT NOT PROCEEDING** *Complete only if patient is not proceeding for further follow up at your service centre.*
Please ensure the patient's primary provider has been notified if the patient is not going to proceed.

☐ Patient not due for screening/surveillance/follow up	☐ Patient has colorectal cancer history
Recall for: ☐ FIT ☐ Colonoscopy	☐ Patient has Crohn's or ulcerative colitis
Specify Future Date (YYYYMM): _____	☐ Patient is deceased
☐ Patient declined	☐ Patient moved out of province
Future Recall Required? ☐ Yes ☐ No	☐ Patient family history does not meet colonoscopy eligibility
Recall for: ☐ FIT ☐ Colonoscopy	☐ Patient is medically unfit for follow up
Specify Future Date (YYYYMM): _____	☐ Patient is symptomatic, provider to refer to specialist
☐ Patient was not able to be contacted	☐ Other: _____

Section B: Patient Not Proceeding	• Select this option if completing this section **ONLY** due to patient not proceeding to colonoscopy.
Patient not due for screening/surveillance/follow up	• Only select this option if the patient is due in more than 3 months. If the patient is due within 3 months, keep the referral and schedule the patient out accordingly using local booking processes – do not complete this form. • Select this option if the patient is not currently due for screening. • Indicate when the patient is due to be recalled and the screening test type indicated for the patient: • Select ONE test type: FIT or Colonoscopy. • Enter the date the patient is next due using the YYYYMM format. This date will be entered into the database to recall the patient (if FIT is selected) or to be referred to the Health Authority Referral Service Centre (for colonoscopy). • Patients who have had a colonoscopy in the past and who have an abnormal FIT result between recommended screening or surveillance are recommended to be booked for colonoscopy. See Pre/Post Colonoscopy Standards and Colonoscopy Standards. • A recall cannot be generated without the date being communicated to BC Cancer. If no date is provided the form will be returned requesting completion.

Patient declined/deferred	• Select this option if the patient has declined proceeding to colonoscopy at the current time.
	• Examples of when to select this option:
	  ○ Patient does not want to have a follow-up colonoscopy (e.g. Patient was not aware that colonoscopy would be a follow-up procedure for screening or patient is opting to complete another FIT).
	  ○ Patient is not available to have their follow-up colonoscopy for a period of time (e.g. travelling, other medical procedures, transient illness, personal reasons).
	• Only select this option if the patient is declining indefinitely or wanting to defer for more than 3 months. If the patient is deferring for 3 months or less, keep the referral and schedule the patient out accordingly using local booking processes – do not complete this form.
	  ○ If the patient can be scheduled in the future (beyond 3 months)

	for the date that they prefer, this should be done – do not complete this form. • If the patient cannot be scheduled at their preferred future date or if the preferred future date is uncertain then complete this section and a new referral will be sent when requested. • Select ONE of Yes or No: • Select "Yes" if future recall is requested by the patient (e.g. the patient is going away, work schedule, personal reasons, etc.) • Select "No" if the patient is declining any further follow-up through the Colon Screening Program. No further recalls or referrals will be sent by the Colon Screening Program to the patient or the Health Authority Referral Service Centre. • If "Yes" is selected, select ONE test type: FIT or Colonoscopy. • Enter the date the patient should be referred/recalled using the YYYYMM format. • This date will be entered into the database to recall the patient (if FIT is selected) or to be referred to the Health Authority Referral Service Centre (for colonoscopy). If the patient is deferring colonoscopy or FIT, document the date of the future recall. A recall cannot be generated without the date being communicated to BC Cancer.
Patient was not able to be contacted	• Select this option if the patient is unable to be contacted for pre-colonoscopy assessment after two attempts, using two different methods of contact. • Consider checking for contact information with the Primary Care Provider's office prior to selecting this option, as many offices re-contact the Colon Screening Program on behalf of their patient requesting re-referral after this option is selected.
Patient has colorectal cancer history	• Select this option if the patient has a personal history of colorectal cancer.
Patient has Crohn's or ulcerative colitis	• Select this option if the patient has a personal history of Crohn's or ulcerative colitis.
Patient is deceased	• Select this option if the patient is deceased.
Patient moved out of province	• Select this option if the patient is no longer living in B.C.
Patient family history does not meet colonoscopy eligibility	• Select this option if the patient does not have a first degree relative (parent, full-sibling or child) with colorectal cancer diagnosed under age 60, or more than 1 first degree relative diagnosed with colorectal cancer any age. • As these patients should be offered FIT screening, advise the patient to return to their health care provider to discuss FIT screening. • If a patient was referred for Family History Colonoscopy screening, but the history does not meet eligibility for colonoscopy and you know when the patient is next due for FIT, complete this as an indication for not proceeding as well as the "Not due" option and indicate when the patient should be recalled for FIT.
Patient is medically unfit for follow up	• Select this option if the patient is medically unfit for colonoscopy. A colonoscopist must be involved in making this determination and may recommend alternative screening methods. • A patient who is medically complex with a number of co-morbidities but determined by a colonoscopist to be fit for colonoscopy should have their colonoscopy in the Colon Screening Program. • See Colonoscopy Standards regarding colonoscopy while on antithrombotics. • If the patient is medically unfit at this time but requires re-referral in more than 3 months, complete the "Not due" reason in addition to this one and enter the date that the patient should be re-referred for

	colonoscopy in YYYYMM format. • If “Medically Unfit” is selected and no recall date is provided in the “Not Due” section, no further recall or referrals will occur for this patient.
Patient is symptomatic, provider to refer to specialist	• Most patients with symptoms can have their colonoscopy through the program. • Select this option if the patient is symptomatic and a colonoscopist has determined that the patient should not have a colonoscopy through the program. • Ensure the primary care provider is advised to refer the patient to a specialist outside of the Colon Screening Program.
Other	• Document any other reason not covered by the above reason selections, for a patient not proceeding to colonoscopy. • *If the patient requires a colonoscopy in Northern Health Authority, select this option and inform the primary care provider to refer the patient to a specialist in NHA.

Patient Coordinator Identifiers

☐ Letter sent to PCP to inform patient not proceeding

COMPLETED BY _____ SIGNATURE _____

Comments (Not captured by program): _____

_____

_____

Letter sent to PCP to inform patient not proceeding	• Health Authority staff are responsible for communicating with the Primary Care Provider directly if a patient is not proceeding to colonoscopy. • A Physician Letter Patient Not Proceeding template is available, on the Teamsite, for Health Authority Staff to complete and send to the Primary Care Provider. • This box should be checked to document that communication was sent.
Completed by	• Enter Health Authority Staff Name who completed the form.
Signature	• Sign the form.
Comments	• Additional lines for Health Authority Staff to make any notes, for internal use only. • Data entered here will not be captured or actioned on by the Colon Screening Program.

Document Change Guide

Date	Version	Type of Change	Change Made	Pages Affected/Location
20200822	August 2020	New document guide	New document guide	All
20201019	October 2020	Word formatting	Date format	Pages 7 and 8
20210325	March 2021	Document updates and examples added.	Updated definition for Health Authority Service Centre. Updated definition for Transfer Request To.	Page 5 Page 6
20211020	October 2021	Document updates and examples added.	Updated definitions with added examples for transfer requests. Updated definition for patient not due. Updated definition for patient declined/deferred. Updated definition for medically unfit scenarios.	Page 6 Page 7 Page 7 Page 8