Colon Screening

Standards: Pre-Post Colonoscopy Standards

September 2019
Acknowledgements

BC Cancer would like to thank everyone who assisted in the development and refinement of the Colon Screening Program’s Standards: Pre and Post Colonoscopy.

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It has been the innovative and transforming work of the Colon Screening Program’s Colonoscopy and Patient Coordinator Working Group that inspired and informed the development of these guidelines. We would also like to thank the management of the BC Cancer Screening Programs, the BC Cancer executive sponsors of the Colon Screening Program, the Provincial Health Services Authority (PHSA), the Ministry of Health, the BC Society of Gastroenterology, the Section of General Surgery, the Society of General Practitioners of BC, the BC Cancer Gastrointestinal (GI) Tumour Group, and the Colon Screening Program Advisory Committee.

About BC Cancer

BC Cancer, an agency of the Provincial Health Services Authority, provides a comprehensive cancer control program for the people of BC in partnership with regional health authorities. This includes prevention, screening and early detection programs, research and education, and care and treatment.

BC Cancer's mandate is a three-fold mission:
• To reduce the incidence of cancer
• To reduce the mortality rate of people with cancer
• To improve the quality of life of people living with cancer

This mission drives everything we do, including providing screening, diagnosis and care, setting treatment standards, and conducting research into causes of, and cures for, cancer.
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1. Introduction

1.1 Colon Screening Program

Colorectal cancer (CRC) is the second most commonly diagnosed cancer and the second leading cause of cancer death in men and third leading cause of cancer death in women\(^1\). The Colon Screening Program seeks to reduce the incidence and mortality of colorectal cancer by providing timely and equitable access to high quality screening and diagnostic services to eligible men and women ages 50 to 74 in BC.

1.2 Purpose of the Standards

These Standards are designed to maximize participant safety and program efficiency and efficacy by ensuring pre and post colonoscopy assessment is carried out in a safe, effective and consistent manner across the province.

1.3 Sources of Information

The Pre-Post Colonoscopy Assessment Standards are based on the experiences of the BC Cancer Colon Check pilot program, the Vancouver Island Health Authority Pilot Program and the NHS Bowel Cancer Screening Programme (UK).

1.4 General Principles

- Maximize follow-up colonoscopy uptake for participants with a positive FIT
- Optimize participant understanding of colonoscopy
- Optimize participant satisfaction
- Minimize colonoscopy related complications
- Optimize follow-up screening and surveillance

1.5 Program Eligibility

Patients are referred to the program by health care providers. Health care providers are provided with information on the eligibility criteria for the program and it is expected that providers consider and adhere to the criteria. However, some health care providers will, at times, refer patients through the program who are outside of the age range or who have symptoms.

If received by the Colon Screening Program, the Program will refer patients with abnormal FIT results or family/personal history criteria on to the patient’s health authority for assessment. BC Cancer is supportive of collecting all data and outcomes for these patients, by completion of the usual model, for patients who are outside the program age range or who may present for assessment with symptoms.
2. Pre-Colonoscopy Assessment

2.1 Assessment and Patient Education

- Contact referred patients and establish a time to complete assessment. Each Regional Health Authority will determine whether the assessment takes place by telephone, in person or through group education sessions. Self-reported height and weight is acceptable for phone assessments.

- Confirm the patient’s primary care provider. A primary care provider is required for patients undergoing colonoscopy to support any follow-up that the patient may need.

- Complete the Assessment Form (see Appendix A).
  - Identify any high risk factors that require colonoscopist assessment prior to colonoscopy and liaise with colonoscopist as indicated. See Section 3 and Patient Assessment Process document.

- Identify the presence of a high-risk family history for hereditary colorectal cancer. If a high-risk family history is identified, advise the patient to discuss their history with their primary care provider.
  - Send page 3 of the Assessment Form to the Colon Screening Program.

- Provide education to the patient regarding:
  - Implications of an abnormal FIT and the reasons for colonoscopy follow-up.
  - Colonoscopy is always indicated after a positive FIT, even if there is a subsequent negative FIT. If the patient has had a colonoscopy within the last five years, then repeat colonoscopy should be at the discretion of the colonoscopists who completed the last procedure.
  - Bowel preparation and colonoscopy.
  - Explain the risks of colonoscopy.
  - Provide the patient with the Colon Screening Program Colonoscopy brochure (sample in Appendix B) to inform them about colonoscopy.
  - Give the patient written bowel preparation instructions, based on the assessment and the colonoscopist’s preference.

- Book patient for colonoscopy:
  - If not proceeding to colonoscopy, advise GP using Not Proceeding to Colonoscopy letter, Appendix C.

- Patients who do not proceed to their colonoscopy within 6 months of the assessment should be reassessed prior to proceeding to colonoscopy.
2.2 Bowel Preparation

Participants should be provided with written preparation instructions as per the Bowel Preparation Algorithm in Appendix G.


Studies have shown that split-dose bowel preparations improve the quality of the bowel preparation as compared to bowel preparations administered the day prior to colonoscopy and this has led to a significant increase in the adenoma detection rate\(^2\).

PEG based regimens are the preferred preparation for:

- Age > 65 years
- Diuretic use
- Renal insufficiency (GFR < 60)
- Diabetes
- Congestive heart failure
- Liver cirrhosis or ascites

If a colonoscopy is incomplete due to a poor bowel preparation, then the colonoscopist should specify the bowel preparation for the next colonoscopy and re-book the patient in a Colon Screening Program slot. After a failed preparation, an individualized bowel preparation will be required. On the Colonoscopy Reporting Form, the colonoscopist will tick the box for “Repeat colonoscopy required”.
3. Alerts for Colonoscopy

3.1 Pre-Colonoscopy Assessment

A pre-colonoscopy questionnaire is a useful tool to identify patients being considered for colonoscopy and polypectomy who may be at increased risk, see Assessment Form (Appendix A). Two methods of contact, separated by a two week interval, is the minimum requirement for contacting patients for colonoscopy assessment. For example, call the patient, wait two weeks, if no response then mail a letter to client requesting they contact the health authority.

Pre-existing medical conditions and medications may conflict with a safe bowel preparation, medications used for sedation, electrocautery equipment or be associated with increased risk of complications.

Each individual is unique and the clinical circumstances with each patient prevent clear guidelines as to appropriate adjustments required in every circumstance of identified increased risk. When in doubt as to the appropriate action, the patient’s family physician and/or the attending colonoscopist should be consulted for clinical direction.

If any of the following conditions exist, then the health authority staff should alert the colonoscopist and the participant may require a consultation prior to colonoscopy. The participant may also see the colonoscopist prior to the colonoscopy at the patient’s request.

GI Symptoms

- Rectal bleeding
- Chronic diarrhea
- Persistent change in bowel habits
- Chronic abdominal pain
- Unexplained weight loss
Significant co-morbid medical illnesses

- Cancer
- Dialysis patients
- Insulin-dependent diabetics
- Bleeding disorders and patients on antithrombotics
- Cardiac disease requiring a pacemaker or defibrillator
- Respiratory disease requiring home oxygen or CPAP
- Congestive heart failure
- Current angina or history of a myocardial infarction
- Cirrhosis with ascites
- Morbid obesity (BMI ≥ 40)

Other

- Participant who will not consent to blood products (e.g. Jehovah’s Witness)

3.2 Antithrombotic Therapy

Antithrombotic agents are medications that prevent blood clot formation and can be divided into anticoagulants and antiplatelet agents. These medications may increase a patient’s risk of bleeding following colonoscopic polypectomy. Non-steroidal anti-inflammatory medications (e.g. ibuprofen, naproxen) are not prescribed to prevent clot formation but as a side effect they do inhibit platelet function and increase the bleeding time. Prospective studies have concluded that aspirin and non-steroidal anti-inflammatory medications can be safely continued for colonoscopy and polypectomy.

Whether a medication is discontinued prior to undergoing colonoscopy involves balancing the risk of bleeding following polypectomy and the risk of clotting if the antithrombotic medication is discontinued. Patients on antiplatelet agents (aside from aspirin and non-steroidal anti-inflammatory medications), anti-thrombin agents and anticoagulants should be reviewed by their health care provider prior to the colonoscopy to decide timing of the colonoscopy, discontinuation of the antithrombotic agent, the need for bridging anticoagulation and when the antithrombotic agent can be restarted. These decisions may be made in conjunction with the patient’s family physician, cardiologist or neurologist.

The following are examples of anticoagulants and antiplatelet agents with the Canadian brand names in brackets. New antithrombotic agents may be available in the near future so this list should not be considered exclusive.
Anticoagulants

Warfarin (Coumadin)
Heparin
Low-molecular weight heparin
  - Enoxaparin (Lovenox)
  - Dalteparin (Fragmin)
Fondaparinux (Arixtra)
Dabigatran (Pradax)
Rivaroxaban (Xarelto)
Apixaban (Eliquis)
Desirudin (Iprivask)

Antiplatelet agents

Aspirin
Cilostazol (Pletal)
Thienopyridine agents
  - Clopidogrel (Plavix)
  - Ticlopidine (Ticlid)
  - Prasugrel (Effient)
  - Ticagrelor (Brilinta)

3.3 Cardiac Defibrillator

Implantable cardiac defibrillators are increasingly common and may be activated inadvertently during endoscopy if electocautery is used.

Most patients with cardiac pacemakers may undergo routine uses of electocautery (i.e. polypectomy) with no alterations in management. Some standard precautions are necessary during the procedure to minimize risk.

In all patients with implanted cardiac devices, determine the type of cardiac device, indication for the device and degree of pacemaker dependence before endoscopy. Most patients carry a wallet card, which identifies the device and contact numbers.

In patients with cardiac defibrillators, consultation with cardiologist is recommended and deactivation of the device by qualified personnel should be considered. Continuous cardiac monitoring during the procedure is recommended. The device should be reprogrammed as soon as possible after the procedure.
3.4 Diabetes

Diabetic patients may experience difficulty with glucose control during the bowel preparation and required fasting prior to colonoscopy. Most patients on oral agents (e.g. Metformin (Glucophage), Glipizide (Glucotrol), Glyburide (Diabeta/Micronase), Pioglitazone (Actos), Rosiglitazone (Avandia), Acorbose (Precose) or Miglitozone (Glyset)) can safely continue the medications until their usual diet is interrupted. During fasting and the bowel preparation time, the drugs should be held. Drugs should be restarted when normal oral intake is resumed after the procedure.

Patients requiring insulin will need to reduce the insulin dosage during fasting for the bowel preparation and day of the colonoscopy procedure. Most patients on insulin have been educated on how to adjust their own insulin during periods of fasting. Patients should be asked to consult with their physician ahead of the procedure.

Patients with diabetes are at increased risk of renal disease and should be questioned as to any pre-existing renal impairment, as this would impact the type of bowel preparation that would be recommended.

3.5 Iron Tablets

Oral iron compounds interact with colonic mucous and dietary compounds and impair the effect of bowel preparations. Patients should be advised to discontinue oral iron preparations 7 days prior to the procedure. Even oral vitamins containing iron are best discontinued to improve colonoscopy quality.

3.6 Glaucoma

Glaucoma (an optic neuropathy due to increased introcular pressure) is present in ~1-8% of individuals over 40 and more common in diabetics. Patients with increased intraocular pressure or glaucoma are often treated with topical eye drop medications. Glaucoma can be aggravated by anti-cholinergic drugs, which are occasionally used during endoscopic procedures to reduced smooth muscle spasm. Glaucoma is usually well controlled with topical medications, which should be continued, and does not interfere with colonoscopy or polypectomy. Anti-spasmodic drugs should be avoided during the procedure.
3.7 Renal Insufficiency/Dialysis

Patients with impairment of renal function can be adversely affected by the dehydrating potential of colonoscopy bowel preparations. Patients with significant kidney disease (i.e. eGFR of less than 60ml/min) should be offered an electrolyte solution containing Polyethylene glycol (PEG) for bowel cleansing.

Patients receiving dialysis who require colonoscopy present challenges for safe, effective bowel preparation that does not seriously affect their fluid balance. Colonoscopy is best scheduled in consultation with the patient’s nephrologists to discuss bowel preparation and appropriate timing of the procedure in relation to the patient’s dialysis times.

Routine antibiotic prophylaxis is not recommended prior to colonoscopy. Antibiotic prophylaxis prior to colonoscopy is recommended for patients undergoing continuous peritoneal dialysis to prevent peritonitis. A single dose of ampicillin plus an aminoglycoside may be given intravenously just prior to the colonoscopy. Intraperitoneal antibiotics the night prior to colonoscopy is an alternative strategy. The abdomen should be emptied of fluid prior to colonoscopy.4,5

3.8 Congestive Heart Failure (CHF)

Patients with congestive heart failure may be at increased risk of complications related to colonoscopy bowel preparation and should be offered the PEG based bowel preparations. Patients with severe congestive heart failure, which causes shortness of breath on exertion or significantly limits activity, require a medical consult before colonoscopy should be considered.
4. Informed Consent

Requirements for written informed consent will differ according to the institution. The Colon Screening Program “What is a Colonoscopy?” brochure provides information on the risks of colonoscopy. This must be provided to each patient, in addition to any institution specific consent requirements. It’s important that the patient be given time to process the consent information and ask questions. The health authority staff will provide the participant with the information necessary to give informed consent. The colonoscopist will obtain consent prior to the procedure.

Colonoscopy has a 5/1000 risk of a serious complication. This includes the following:

- Reaction to the bowel preparation
- Reaction to the medication used for sedation
- Cardiopulmonary event
- Infection
- Bleeding (<1/1000)
- Perforation (<1/1000)

The chance of death from colonoscopy is 1/14,000.

The chance of a significant abnormality being missed is 1/10.

Additional information to answer participant’s questions is provided below.

- Cardiopulmonary event refers to desaturation, low blood pressure and rarely angina or myocardial infarction.
- Infection refers to phlebitis related to the IV, pneumonia (aspiration), and diverticulitis. Infection can be transmitted by the colonoscope between patients or from a contaminated water supply. If infection is transmitted between patients, it indicates an error has occurred in the colonoscope cleaning.
- Bleeding is almost always at the site of a polyp removal. It is usually self-limited but will occasionally require hospital admission with a repeat colonoscopy, blood transfusion, radiologic intervention or surgery.
- Perforation is usually at the site of a polyp removal. It almost always requires surgery.
5. Post Colonoscopy Assessment

5.1 Telephone Follow-up at 14 Days

Fourteen days after the procedure, the health authority staff will contact the patient. Two methods of contact, separated by a two week interval, is the minimum requirement for contacting patients for colonoscopy assessment. For example, call the patient, wait two weeks, if no response then mail a letter to client requesting they contact the health authority. The purpose of the 14-day telephone interview is to:

- assess for any unplanned events following colonoscopy and
- recommend the next re-screening or surveillance interval

5.2 Unplanned Events

Any unplanned event occurring the day before or following colonoscopy should be recorded using the Unplanned Event Form (Appendix D). A serious adverse event is an adverse event that results in a hospitalization, blood transfusion, interventional radiology procedure, other intervention, surgery, or death.

5.3 Re-screening and Surveillance Guidelines

The health authority staff should review the patient’s pathology report and the recommendations in the Colonoscopist’s Procedure Report. If recommendations differ from the re-screening or surveillance guidelines outlined in the Colonoscopy Standards document, then the next recommended screening type and interval should be discussed with the colonoscopist.

Complete the Follow-Up Form (Appendix E) based on the guidelines and colonoscopist’s recommendations and fax the form to the Colon Screening Program. The Program will generate a letter outlining re-screening/surveillance recommendations to be sent to the family physician, colonoscopist and health authority staff who completed the assessment.

Deviations in the recommendations are appropriate under certain circumstances. Examples are in the Colonoscopy Standards.

The only reasons for a participant to leave the Colon Screening Program are for age > 74 years, a diagnosis of colorectal cancer and a diagnosis of ulcerative or Crohn’s colitis. Individuals with Lynch Syndrome or Attenuated Familial Adenomatous Polyposis require screening for other malignancies and should also be managed outside the Colon Screening Program by a colonoscopist with expertise in hereditary colon cancer syndromes. All other participants should continue to be screened in the Colon Screening Program and if their screening needs to be individualized, then this can be done by citing a deviation and explanation on the Follow-up Form.
While there may be an indication to do a colonoscopy at an earlier interval, there is never an indication to do a FIT at an earlier interval. If a colonoscopy is not high quality the patient should have a repeat colonoscopy as soon as possible and certainly within 1 year.

If the colonoscopist disagrees with the Colon Screening Program's recommendations and decides upon a different FIT follow-up interval for a patient who has undergone a high quality colonoscopy, then this will need to be arranged by the colonoscopist outside of the Colon Screening Program. Unfortunately, the primary care provider will receive two different recommendations - those in the colonoscopy report and those from the program.

Regarding participants with an abnormal FIT and a colonoscopy without a cancer or polyp, the participant will be recalled to undergo repeat FIT in 10 years. Follow-up Forms received by the program that indicate a deviation with FIT prior to the 10 year recall will not have the deviation entered and the follow-up letter to the colonoscopist, health authority staff and primary care provider will indicate rescreening or surveillance based on current guidelines.

Colonoscopies performed within the Colon Screening Program may reveal significant findings beyond the scope of the program. For instance, participants diagnosed with anal intraepithelial neoplasia or squamous cell carcinoma of the anus, carcinoid tumors, gastrointestinal stromal tumors, or Peutz-Jehger polyps. In this situation, the colonoscopist, should either arrange follow-up or guide the primary health care provider in the appropriate management. These participants will remain in the Colon Screening Program and be re-called at the appropriate interval for re-screening or surveillance as outlined above.
6. Quality Assurance

6.1 Data Collection

Each colonoscopy unit will need a quality program in place. The Colon Screening Program has a central database where the performance indicators will be maintained and reported back to Health Authorities. By providing complete and accurate information on the relevant forms, health authority staff will help with appropriate data collection for performance indicator and patient outcome monitoring.

6.2 Pre-Post Colonoscopy Assessment Performance Indicators

- Number of patients not proceeding to colonoscopy due to poor medical fitness
- Compliance with follow-up colonoscopy
- No show rate for colonoscopy
- Time from positive FIT to colonoscopy
- Number of patients deemed medically unfit by colonoscopist at time of colonoscopy (i.e. prepped for procedure but medically unfit)
- Bowel preparation quality
- Patient, primary care provider, colonoscopist satisfaction with pre-post colonoscopy assessment
- Time from referral to first attempted patient contact by health authority staff
7. Medical Records

7.1 Medical Record Retention Policy

The Health Authority is the primary record holder for documentation pertaining to pre and post colonoscopy assessment. Health Authorities follow their own policies with respect to record retention and documentation. The Colon Screening Program is a secondary user of the forms and records that are completed for program participants. Patients and providers requesting copies of their screening record will be directed to obtain copies from the facility where the interaction occurred.
8. References


## Assessment Form

**INSTRUCTIONS:** Fax page 3 to the Colon Screening Program

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<td>PATIENT'S PREFERRED NAME</td>
<td>ASSESSMENT DATE (dd/mm/yy)</td>
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### Alerts for Colonoscopy:
- Anticoagulation
- Antiplatelet agent
- Defibrillator/Pacemaker
- Diabetic insulin/tablets
- Sleep Apnea
- Iron tablets (stop 7 days)
- Glaucoma
- COPD
- CHF
- No blood transfusions
- Renal insufficiency/Dialysis
- Contact Precaution (specify):

### Symptoms (within last 6 months)

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<td>Recent changes in bowel habits</td>
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<td>Diarrhea</td>
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<td>Constipation</td>
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<td>Rectal bleeding</td>
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<td>Bowel urgency</td>
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<td>Unexplained weight loss</td>
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<td>Abdominal pain</td>
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<td>Upper GI Symptoms (eg. N&amp;V, swallowing difficulties, GERD)</td>
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### Reason for Colonoscopy Assessment:
- NG = FIT
- Family History
- Surveillance/Deviation

### Medication

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### Allergies
- NKA

### Comments

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**FORM: 21100  VERSION: 27FEBRUARY2018**  
801-686 West Broadway | Vancouver, BC | V5Z 1G1 | 1-877-70-COLON | www.screenebc.ca

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<table>
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<th>Patient Name</th>
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<td>Cardiac (e.g., AF, PPM, ICD, CHF)</td>
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<td>Hypertension</td>
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<td>Respiratory (e.g., sleep apnea, asthma, COPD)</td>
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<td>Liver</td>
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<td>Renal (e.g., document eGFR &lt;60ml/min, creatinine &gt;200umol/L, if known)</td>
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</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
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<tr>
<td>Bleeding disorder</td>
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<tr>
<td>Blood transfusion concerns (e.g., Jehovah's witness)</td>
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</tr>
<tr>
<td>Problems with sedation or anaesthesia</td>
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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 (e.g., MS) □ Learning disability
□ Blind/partially blind □ Deaf/HHH □ Other (specify): ____________________________

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

EIOH: □ No □ Yes
units / week: __________

Recreational or illicit Drug Use: □ No □ Yes
Substance: __________ Frequency: __________

Height (cm): __________ Weight (kg): __________ BMI: __________
Assessment Form

INSTRUCTIONS: Fax this page to the Colon Screening Program 1-604-297-9340

<table>
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<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH (dd/mm/yy)</th>
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Date Patient 1st Contacted (dd/mm/yy)

Assessment date (dd/mm/yy)

Amended Ax date (dd/mm/yy)

Assessment

- In Person
- By Phone
- Patient Not Contacted

FOR ALL PATIENTS

Family History: 1st degree relative CRC: □ No □ Yes □ More than three 1st degree Relatives

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<th>Age of Diagnosis</th>
<th>Any relatives with HNPCC connected Cancers?</th>
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<td></td>
<td></td>
<td>□ No □ Yes (specify):</td>
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Patient proceeding to colonoscopy as part of the Colon Screening Program

1st available date (dd/mm/yy)

Booked date (dd/mm/yy)

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:
- Teaching date/times:
- Teaching Coordinator:

Patient instructions (if applicable)

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

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
- Family history does not meet colonoscopy eligibility

- Patient is not proceeding at this time but a future recall is required - future date (mm/yy):
- FT
- Colonoscopy

Colonscopist consult required:

Comments:

Colonscopist consult required:

Hospital Referral:

Patient Coordinator Name

Patient Coordinator Signature

Location

Page 3 of 4

FORM: 21100 VERSION: 27FEBRUARY2018

801-566 West Broadway | Vancouver, BC | V5Z 1G1 | 1 677-70 COLON | www.screeningbc.ca
<table>
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Appendix B – Colonoscopy Brochure

Who should get a colonoscopy?
Colonoscopy is recommended for women and men ages 50-74 who have at least one of the following:
• An abnormal fecal immunochemical test (FIT) result; or,
• One first degree relative (mother, father, sister, brother, daughter or son) with colon cancer diagnosed under the age of 60; or,
• Two or more first degree relatives with colon cancer diagnosed at any age; or,
• A personal history of adenomas. Adenomas are a type of precancerous polyp.

Before the colonoscopy
• Expect to be at the hospital for two to three hours.
• You will be asked to change into a gown.
• A nurse will complete your admission history and measure your vital signs.
• You will be asked to provide a list of your medications.
• A nurse will start an intravenous (IV) to administer sedation and pain medication.

After the colonoscopy
• Have an adult accompany you home. You cannot drive until the following day.
• You may be sleepy after you arrive home from the procedure. It is recommended that you do not operate equipment, sign legal papers or drink alcohol until the following day.
• You will be able to resume your regular diet and medications after your colonoscopy, unless otherwise directed by your patient coordinator or colonoscopist.
• The air inside your colon may cause you to feel bloated and/or have cramping after the procedure. It is important to relax and pass the air as soon as possible. If this discomfort increases or is unrelieved, go to the emergency department and advise them that you had a colonoscopy.

Colon cancer is one of the most commonly diagnosed forms of cancer, affecting one in six people in British Columbian. Screening procedures, such as colonoscopies, can detect the early warning signs of colon cancer and save your life.

Colonoscopy is a procedure that allows a colonoscopist to see the inside lining of the rectum and colon using a special instrument called a colonoscope.

A colonoscope is a flexible tube with a miniature camera attached to one end so that the colonoscopist can take pictures and videos of your colon. During a colonoscopy, tissue samples can be collected and polyps can be removed.

Things to know
• The procedure is performed by a colonoscopist and usually takes 20 to 65 minutes to perform.
• You will be closely monitored before, during and after the procedure.
• It is normal throughout the procedure to feel slight pressure or experience cramps.
During the colonoscopy:

1. A colonoscopist inserts the colonoscope into the rectum and advances it along the length of the colon.

2. Air is sent through the colonoscope to expand the colon for better viewing.

3. Images of the lining of the rectum and colon are sent to a video monitor where the colonoscopist will look for anything unusual, like a polyp. A polyp is a small growth of tissue on the wall of the intestine.

4. Polyps can grow very slowly, and some can become cancerous. It may be necessary to take a sample (biopsy) or remove the polyp (polypectomy). This is painless.

5. The biopsy or polyp is then sent to a lab for analysis.

Results

You will be given preliminary results before you leave the hospital. Then, approximately two weeks after your procedure, the patient coordinator or the colonoscopist will inform you of your complete results and answer your questions during the follow up call. Your doctor will also receive your results.

If your colonoscopy is normal, your personal history will determine when you will be re-screened. Your patient coordinator or colonoscopist will advise you of your next screening date.

If your colonoscopy is abnormal, further procedures or more regular surveillance may be necessary. The patient coordinator, colonoscopist, or your doctor will explain the process for further appointments and next steps.

Risks

As with any medical procedure, colonoscopy has a small risk of complications.

Approximately 5/1,000 people will have a serious complication. Complications can include a reaction to the bowel preparation or medication used for sedation, heart or lung problems, an infection, bleeding from the colon and/or perforation of the colon (hole in the colon).

If a complication occurs, treatment including antibiotics, blood transfusion, hospitalization, repeat colonoscopy or surgery may be required. The risk of dying from colonoscopy is less than 1/14,000. There is also a risk of missing a significant abnormality. This occurs in less than 1/10 cases.

Contact us:
Colon Screening Program
801–686 West Broadway,
Vancouver, BC V5Z1G1
1:800-663-9203
www.screeningbc.ca/colon
Appendix C - Sample Not Proceeding to Colonoscopy Letter

Dear Dr. __________________________ Fax # __________________________ Date __________________________

Patient Name __________________________ PHN __________________________ DOB __________________________

1. Your patient was referred for pre-colonoscopy assessment on _____________ (date) due to:
   - ☐ Abnormal FIT
   - ☐ Family History
   - ☐ Surveillance Requirement

2. Your patient has NOT been booked for a colonoscopy procedure due to:
   - ☐ Patient has a history of inflammatory bowel disease (Crohn's or ulcerative colitis). Please refer the patient to his/her specialist for ongoing care and monitoring. The patient will not be recalled by the Colon Screening Program.
   - ☐ Patient has a history of colorectal cancer. Please refer the patient to his/her specialist for ongoing care and monitoring. The patient will not be recalled by the Colon Screening Program.
   - ☐ Patient indicated symptoms. Please refer the patient directly to a specialist for assessment. The patient will not be recalled by the Colon Screening Program.
   - ☐ Your patient does not meet the age eligibility for programmatic screening. There may be indications for screening patients over or under the target age of 50-74. If you feel this is the case, please refer your patient directly to a specialist for consideration of colonoscopy.
   - ☐ Medically unfit for colonoscopy. Colonoscopy has been deferred to _____________ (date) and the Program will recall the patient at that time. If no date is indicated, the patient will not be recalled by the Colon Screening Program. The patient was assessed by a Colonoscopy on _____________ (date).
   - ☐ Family history information does not meet colonoscopy screening eligibility for the Colon Screening Program. Please provide a requisition for FIT screening for this patient or refer directly to a specialist for consideration of colonoscopy.
   - ☐ Your patient does not meet eligibility for colonoscopy screening as he/she is up to date with colon screening. The patient will be recalled by the Program when he/she is next due for screening _____________ (date).
   - ☐ Patient has an abnormal FIT but has had a colonoscopy within the past 5 years. Based on the Colonoscopy/previous assessment, repeat colonoscopy is not required prior to this time. If the colonoscopy was done through the Program, the patient will be recalled when they are due _____________ (date). If the colonoscopy was NOT done in the Program, we are unable to recall them. Please re-refer them to the Program when the patient is next due.
   - ☐ Patient declined proceeding to colonoscopy. The patient will not be recalled by the Colon Screening Program. If your patient elects to proceed with colonoscopy in the future, please send the Program a Colonoscopy Referral Form.
   - ☐ We were unable to reach your patient to complete a pre-colonoscopy assessment. A letter was sent to your patient to advise that they have not been booked for a colonoscopy. The patient will not be recalled by the Colon Screening Program. If the patient wishes to participate in the future, please send the Program a Colonoscopy Referral Form.
   - ☐ Other __________________________________________________________

Sincerely,

Patient Coordinator Name
Health Authority Name

COLON SCREENING PROGRAM
HA Contact Phone #

Version 1.1 23 Jan 2015
Appendix D – Unplanned Events Form

Pre/Post Colonoscopy Unplanned Event

INSTRUCTIONS: Fax to the Colon Screening Program

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATE OF BIRTH (dd/mm/yy)</th>
<th>PHN</th>
</tr>
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<table>
<thead>
<tr>
<th>GP</th>
<th>COLONOSCOPIST</th>
<th>COLONOSCOPY DATE (dd/mm/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DATE OF ONSET OF SYMPTOMS (dd/mm/yy)</th>
<th>Symptoms Ongoing?</th>
<th>No</th>
<th>Yes</th>
<th>DATE OF RESOLUTION OF SYMPTOMS (dd/mm/yy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- Bowel prep complication
- Rectal Bleeding → Anticoagulation: No Yes
- Perforation
- Respiratory
- Cardiac
- Death: Date of death: Cause of death:
- Other (specify):
- Comments:

Patient first obtained medical attention: (dd/mm/yy)

- Family Physician
- Emergency Room
- Other

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

- Blood transfusion
- Additional Colonoscopy: (dd/mm/yy)
- Antibiotics
- Other:
- Surgery (dd/mm/yy)
- Hospital admission (dd/mm/yy) to (dd/mm/yy)

Comments:

Patient Coordinator Name

Patient Coordinator Contact Number

Patient Coordinator Signature

Follow-up Date

COLON SCREENING PROGRAM ADMINISTRATIVE USE ONLY:

SAE: No Yes Related to Scope: Probably Possibly Unlikely QM Review Date: Comments:
Appendix E – Follow Up Form

Follow up Recommendations

INSTRUCTIONS: Fax a copy to the Colon Screening Program: 1-604-297-9340

GP / NP

PATIENT NAME

DATE OF BIRTH (dd/mm/yy)

PHN

COLONOSCOPIST

COLONOSCOPY DATE (dd/mm/yy)

FOLLOW-UP DATE (dd/mm/yy)

☐ Partial follow-up only (complete unplanned event section only), repeat colonoscopy required and was indicated on CRF

1) Unplanned Events

Did the patient require medical attention the day prior to the procedure or up to 14 days after colonoscopy?

☐ No ☐ Yes ☐ Unable to contact

☐ If yes, please complete Unplanned Event form

2) Summarization of Colonoscopy Findings (Clinical/Pathology) (Please select one option)

☐ Hyperplastic polyp removed, other findings or no polyps found (please specify):

☐ No family history of CRC or 1 first degree relative with CRC diagnosed after age 60 (FIT re-screening in 10 years)

☐ 1 first degree relative with CRC diagnosed before age 60 or 2 or more first degree relatives with CRC at any age

☐ Repeat colonoscopy in 5 years

☐ Personal history of adenoma(s) (Repeat colonoscopy in 5 years)

☐ Adenoma removed (please specify):

☐ < 3 low risk adenomas (Repeat colonoscopy in 5 years)

☐ ≥ 3 low risk adenomas or high risk* polyp removed (Repeat colonoscopy in 3 years)

☐ *a high risk polyp has villous features, high-grade dysplasia or ≥ 10 mm. Sessile serrated adenomas with dysplasia and traditional serrated Adenomas are high risk.

☐ Other (please specify):

☐ Colorectal adenocarcinoma identified: Recommendations per medical team. Patient no longer followed by Program.

☐ Inflammatory bowel disease identified: Recommendations per medical team. Patient no longer followed by Program.

3) Follow Up Recommendations (Please select one option)

☐ Follow up as per Colon Screening Program Re-Screening and Surveillance Guidelines (as above)

☐ Follow up deviates from Colon Screening Program Re-Screening and Surveillance Guidelines (as below)

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<th>☐ Months</th>
<th>☐ Years</th>
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<tbody>
<tr>
<td>Reason:</td>
<td>☐ Incomplete Visualization</td>
<td>☐ Adequacy of polypectomy uncertain</td>
</tr>
<tr>
<td></td>
<td>☐ Bowel prep</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Cecum not intubated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Other _____________________</td>
<td></td>
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</table>

4) Other ☐ Patient required surgery for polyp removal ☐ Patient required CT colonography for complete visualization

☐ Normal CTC, FIT rescreening in 5 years

Patient Coordinator Name

Patient Coordinator Signature

Date Signed (dd/mm/yy)
# Appendix F - Colonoscopy Reporting Form

## Colonoscopy Reporting Form

**BC CANCER**

**Colonoscopy Reporting Form**

**PRESS FIRMLY TO ENSURE LEGIBILITY FOR MULTIPLE COPIES**

**FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297-0840**

**GREY SECTIONS TO BE COMPLETED AS REQUIRED**

---

**Exam Date:** [ ]

**Start Time:** [ ]

**PAX:**

**Date of Birth:** [ ]

**Facility Name:**

**Exam Date (YY/MM/DD):**

**Patient Name Last:**

**Patient Name First:**

**Sex:**

**Colonoscopy (MSC):**

**Colonoscopy First, Last:**

**Primary Provider (MSC):**

**Primary Provider First, Last:**

---

Reason for Colonoscopy (select one):

- [ ] FIT
- [ ] Family History
- [ ] Surveillance
- [ ] Deviation
- [ ] No Show for Colonoscopy
- [ ] Medically unfit day of procedure

---

1. BOWEL PREPARATION

- [ ] Excellent
- [ ] Good
- [ ] Fair (adequate to visualize all polyps > 5mm)
- [ ] Poor (inadequate to visualize all polyps > 5mm)

---

2. CECA LINTUBATION (or ileocolic anastomosis reached)

- [ ] Yes → Photo documentation
- [ ] No
- [ ] Yes
- [ ] No
- [ ] Uncertain
- [ ] Flexible sigmoidoscopy

---

3. UNPLANNED EVENTS

- [ ] None

---

4. SPECIMENS TAKEN

- [ ] Yes
- [ ] No

5. WITHDRAWAL TIME: [ ] (Minutes)

---

6. [ ] Additional specimens recorded on Page 2

7. [ ] Repeat Colonoscopy

**Complete Colonoscopy Reporting Form for Next Scope**

---

**Specimen Type**

- B = Biopsy
- P = Polyp

**Location**

- A = Assessing Colon
- B = Biopsy
- C = Crohn’s
- D = Descending
- E = Diverticular
- F = Foregut
- H = Hepatic Flexure
- I = Ileocecal Valve
- M = Mucosa
- S = Splenic Flexure
- U = Uncinate

**Morphology**

- Y = Yes
- N = No
- U = Uncertain

**Removal Mode**

- P = Polypectomy
- F = Forceps
- S = Snare
- C = Crevice

**Send Copies of Pathology Report To:***

1. BC Cancer Colon Screening
   - Fax: 1 (604) 297-9340
2. Other (Name & MSC)
3. Other (Name & MSC)
4. Other (Name & MSC)

**Specimen tracking required by facility?**

- [ ] No
- [ ] Yes

**Number of specimens sent to collection area:**

**Number of specimens transported to lab:**

**Number of specimens received by lab:**

---

**Pathology Copy** | Fax this copy to 1 (604) 297-9340

---

**Page 28**
Appendix G – Bowel Preparation Algorithm

Bowel Preparations

**High Volume (4L PEG)**
- Consider for:
  - Constipation
  - Previous poor preparation
  - Narcotic use
  - Poor mobility
  - Morbid obesity
- Examples:
  - CoLyte
  - GoLYTELY
  - Peglyte

**Low Volume (PEG / 2L PEG)**
- Examples:
  - Bi-PegLyte (do not take Bisacodyl)
  - Moviprep

**Low Volume (Hyperosmolar)**
- Examples:
  - PicoFlo
  - PicoSalax
  - Purg-Odan

Split-dose regimens are preferred.

PEG-based regimens are the preferred preparation for:
- Age > 65 years
- Diuretic use
- Renal insufficiency (GFR < 60)
- Diabetes
- Congestive heart disease
- Liver cirrhosis or ascites

Adjuncts (bisacodyl, magnesium citrate, enemas) are not recommended for standard bowel preparations.

Participants requiring a repeat colonoscopy due to a poor preparation should have their preparation directed by the colonoscopist.

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<td>6,17</td>
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