

Documentation Guide: Colonoscopy Referral Form

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Audience

The Health Care Provider is responsible for registering new patients into the BC Cancer Colon Screening Program.

Introduction

Colonoscopy Referral Form instructions are provided in this document to ensure standardized eligibility and promote correct registration of new patients across B.C. into the Colon Screening Program. The documentation provided on the Colonoscopy Referral Form is used by BC Cancer to support patients being referred to the program and assessed by the appropriate Health Authority referral service centre staff. The data on this form is used to report on program indicators including Health Care Provider Reports and is used as a source for recalling patients based on previous colonoscopies.

Once completed, fax the Colonoscopy Referral Form to the Colon Screening Program and the data will be entered into the Colon Screening Program IT system. This ensures that the patient will be referred to their local Health Authority and, when applicable, the patient is recalled by the Colon Screening Program at the next recommended re-screening/surveillance interval.

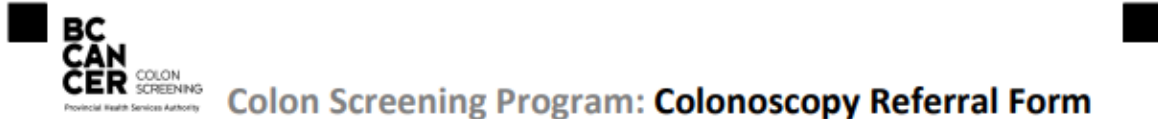
Please do not fax the Colonoscopy Referral Form to the Colon Screening Program until documentation is complete. Colonoscopy Referral Forms with missing documentation or conflicting documentation will be returned for correction.

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 Colonoscopy Referral Form



STEP 1 Complete Provider and Patient Information

PHN NUMBER		OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)		ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #)	
PATIENT LAST NAME		PATIENT FIRST NAME		MSC	
DATE OF BIRTH (DD-MMM-YYYY)		SEX <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U		PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #)	
PATIENT ADDRESS		CITY/TOWN PROVINCE		MSC	
PATIENT HOME NUMBER	PATIENT CELL PHONE NUMBER	POSTAL CODE		PROVIDER SIGNATURE	
LANGUAGE PREFERRED		REFERRAL DATE (DD-MMM-YYYY)			

STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy

Patients are **excluded** from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:

- Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required.
- Have a personal history of colorectal cancer, ulcerative colitis or Crohn’s disease. These individuals should continue to obtain care through their specialist or health care provider.
- Are on a definite surveillance plan through a specialist.
- Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome).

Screening Colonoscopy (Do not order FIT for these patients)

Recommended for individuals up to age 74 (inclusive), at higher than average risk.

Family History

For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.

- One first degree relative with colorectal cancer diagnosed under the age of 60; or,
- Two or more first degree relatives with colorectal cancer diagnosed at any age; or,

Personal History

- A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)

DUE NOW

DUE: _____ (MMM-YYYY)

Colonoscopy for Abnormal FIT (for individuals ages 50-74 only)

- Abnormal FIT Result date: _____ (DD-MMM-YYYY)

For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)

Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required).
 Planned Procedure Date: _____ (DD-MMM-YYYY) Endoscopy Unit: _____

Select at least one indication:

Abnormal FIT Personal Hx of Adenomas FHx (1st Degree relative < 60 y.o.) FHx (2+ 1st Degree relatives)

STEP 3 Fax Form to BC Cancer Colon Screening: 1-604-297-9340

Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.

Facsimile communications are intended only for the use of the addressee and may contain information that is privileged and confidential. Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited. If you receive this communication in error, please notify the Colon Screening Program immediately by telephone at 1-877-702-6566.



Patient/Provider Identifiers

STEP 1 Complete Provider and Patient Information		
PHN NUMBER	OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)	ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #)
PATIENT LAST NAME	PATIENT FIRST NAME	MSC
DATE OF BIRTH (DD-MMM-YYYY)	SEX <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U	PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #)
PATIENT ADDRESS	CITY/TOWN PROVINCE	MSC
PATIENT HOME NUMBER	PATIENT CELL PHONE NUMBER	POSTAL CODE
LANGUAGE PREFERRED	REFERRAL DATE (DD-MMM-YYYY)	PROVIDER SIGNATURE

PHN REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's Personal Health Number. If the patient does not have a Personal Health Number, indicate the alternate health number.
Other Health Number	<ul style="list-style-type: none"> Indicate the patient's alternate health number (i.e. REF, CAF, CSC, etc.)
Patient Name Last REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's last name in block letters.
Patient Name First REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's first name in block letters.
Date of Birth REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's date of birth using the DDMMYYYY format.
Sex REQUIRED FIELD	<ul style="list-style-type: none"> Indicate sex of patient either F, M, X or U.
Patient Address REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's primary address of residence.
Patient City/Town REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's primary address, city or town of residence.
Patient Province REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's province of residence.
Patient Telephone Number REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's primary telephone number for contact.
Patient Postal Code REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the patient's primary address postal code.
Language Preferred	<ul style="list-style-type: none"> Indicate the preferred language of the patient for their pre-colonoscopy assessment.
Referral Date REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the date you have completed and fax the form to BC Cancer at 604-297-9340.
Ordering Provider REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the health care provider's last and first name in block letters. This is the provider that has requested the referral to the Colon Screening Program.
Ordering Provider MSC REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the ordering provider's 5 digit MSC number.

Primary Care Provider REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the health care 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.
Primary Care Provider MSC REQUIRED FIELD	<ul style="list-style-type: none"> Indicate the health care provider's 5 digit MSC number.
Provider Signature	<ul style="list-style-type: none"> Signature of the health care provider completing the Colonoscopy Referral Form for the patient

To be completed by Primary Care Provider and/or Colonoscopists: Reason for Referral

Complete this section when the patient has not yet been referred for colonoscopy.

This section can also be used by health care providers and/or colonoscopists to request a future recall for a patient. For example, when a patient has been screened previously and the follow-up recommendations have not been recorded with the Colon Screening Program, and the patient will be due in three or five years for colonoscopy.

<p>STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy</p> <p>Patients are excluded from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:</p> <ul style="list-style-type: none"> Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required. Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider. Are on a definite surveillance plan through a specialist. Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome). <p>Screening Colonoscopy (Do not order FIT for these patients) Recommended for individuals up to age 74 (inclusive), at higher than average risk.</p> <p>Family History For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.</p> <p><input type="radio"/> One first degree relative with colorectal cancer diagnosed under the age of 60; or, <input type="radio"/> Two or more first degree relatives with colorectal cancer diagnosed at any age; or,</p> <p>Personal History <input type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)</p> <p>Colonoscopy for Abnormal FIT (for individuals ages 50-74 only) <input type="radio"/> Abnormal FIT Result date: <input type="text"/> (DD-MMM-YYYY)</p> <p><input type="radio"/> DUE NOW <input type="radio"/> DUE: <input type="text"/> (MMM-YYYY)</p>	
Screening Colonoscopy Reason for Referral	<ul style="list-style-type: none"> Indicate the reason(s) for referral to the Colon Screening Program. e.g. Family History, Personal History, Abnormal FIT
Patient DUE NOW	<ul style="list-style-type: none"> Indicate this option if the patient is due now, or overdue, and should be referred to their local health authority immediately.

Patient DUE	<ul style="list-style-type: none"> Indicate this option if the patient completed a colonoscopy outside of the program and you would like to register the patient for a follow up colonoscopy at a future date. The Colon Screening Program will send a referral to the primary care provider and the patient's local health authority when they are due based on the date provided in this section. Indicate the due date using the MMMYYYY format.
Colonoscopy for Abnormal FIT	<ul style="list-style-type: none"> Indicate that the reason for referral being due to an abnormal FIT lab result. Provide the date of the FIT using the DDMMYYYY format

To be completed by Colonoscopist ONLY: Reason for Referral

The following section of the form is to be used by colonoscopists for patients that have been referred directly to their office for pre-colonoscopy assessment and the colonoscopist would like the patient to be registered and followed in the Colon Screening Program. The specialist would complete the pre-colonoscopy assessment and book the patient for the procedure. The information here will be provided to the Health Authority staff for them to know when to complete follow-up recommendations for the patient. No pre-colonoscopy assessment will be requested.


The patient has completed/will complete a colonoscopy within the program. Colonoscopists will be expected to complete a Colonoscopy Referral Form if they plan to complete a Colonoscopy Reporting Form at the time of the colonoscopy (see Appendix F).

<div style="border: 1px dashed black; padding: 10px;"> <p>For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)</p> <p><input type="radio"/> Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required).</p> <p>Planned Procedure Date: <input type="text"/> Endoscopy Unit: <input type="text"/></p> <p style="text-align: center;"><small>(YYYYMMDD)</small></p> <p>Select at least one indication:</p> <p><input type="radio"/> Abnormal FIT <input type="radio"/> Personal Hx of Adenomas <input type="radio"/> FHx (1st Degree relative < 60 y.o.) <input type="radio"/> FHx (2+ 1st Degree relatives)</p> </div>	
Register Patient	<ul style="list-style-type: none"> Indicate that the patient should be registered into the Colon Screening Program based on a colonoscopy booked in the program.
Planned Procedure Date	<ul style="list-style-type: none"> Indicate the date of the planned colonoscopy, or the date of the colonoscopy that has recently occurred. This date should be a booked colonoscopy procedure date, and

	NOT be a future recall date. Indicate the date using the YYYYMMDD format.
Endoscopy Unit	<ul style="list-style-type: none"> Indicate that the facility of the colonoscopy so that the appropriate Health Authority Service Centre staff will receive the referral.
Reason for referral	<ul style="list-style-type: none"> Indicate the reason(s) for referral to the Colon Screening Program. e.g. Family History, Personal History, Abnormal FIT


Appendix A

Health Care Provider referral example for a patient who is 40 years of age with two first degree relative (2 FDR) (parent, child, full sibling), who is now due based on having two FDR diagnosed with CRC more than 60 years of age. This patient will be referred to their local health authority and will be contacted for a pre-colonoscopy assessment as soon as possible depending on the current wait times.

BC CAN CER COLON SCREENING Provincial Health Services Authority			Colon Screening Program: Colonoscopy Referral Form		
STEP 1 Complete Provider and Patient Information					
PHN NUMBER 9123456789		OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)		ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE MSC 1 2 3 1 2	
PATIENT LAST NAME LAST2		PATIENT FIRST NAME FIRST2		PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE MSC 1 2 3 1 2	
DATE OF BIRTH (DD-MMM-YYYY) 12 FEB 1986		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U			
PATIENT ADDRESS 321 STREETNAME		CITY/TOWN CITY		PROVINCE BC	
PATIENT HOME NUMBER 778-545-1234		PATIENT CELL PHONE NUMBER 604-123-4567		POSTAL CODE V1A2B5	
LANGUAGE PREFERRED PUNJABI		REFERRAL DATE (DD-MMM-YYYY) 05 MAR 2026		PROVIDER SIGNATURE	
STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy					
Patients are excluded from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:					
<ul style="list-style-type: none"> Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required. Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider. Are on a definite surveillance plan through a specialist. Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome). 					
Screening Colonoscopy (Do not order FIT for these patients)					
Recommended for individuals up to age 74 (inclusive), at higher than average risk.					
<u>Family History</u>					
For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.					
<input type="radio"/> One first degree relative with colorectal cancer diagnosed under the age of 60; or, <input checked="" type="radio"/> Two or more first degree relatives with colorectal cancer diagnosed at any age; or, <input type="radio"/> DUE NOW					
<u>Personal History</u>					
<input type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s) <input type="radio"/> DUE: _____ (MMM-YYYY)					
Colonoscopy for Abnormal FIT (for individuals ages 50-74 only)					
<input type="radio"/> Abnormal FIT Result date: _____ (DD-MMM-YYYY)					
For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)					
<input type="radio"/> Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required).					
Planned Procedure Date: _____ (DD-MMM-YYYY)		Endoscopy Unit: _____			
Select at least one indication:					
<input type="radio"/> Abnormal FIT <input type="radio"/> Personal Hx of Adenomas <input type="radio"/> FHx (1st Degree relative < 60 y.o.) <input type="radio"/> FHx (2+ 1st Degree relatives)					
STEP 3 Fax Form to BC Cancer Colon Screening: 1-604-297-9340					
Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.					
Facsimile communications are intended only for the use of the addressee and may contain information that is privileged and confidential. Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited. If you receive this communication in error, please notify the Colon Screening Program immediately by telephone at 1-877-702-6566.					
Co007 - Jan 2026		20840 			

Appendix B

Health Care Provider referral example for a patient who is 35 years of age with one first degree relative (1 FDR) (parent, child, full sibling) who is now due based on having one FDR diagnosed with CRC at 45 years of age. This patient will be referred to their local health authority and will be contacted for a pre-colonoscopy assessment as soon as possible depending on the current wait times.

BC CAN CER COLON SCREENING Provincial Health Services Authority				Colon Screening Program: Colonoscopy Referral Form	
STEP 1 Complete Provider and Patient Information					
PHN NUMBER 9123456789		OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)		ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE MSC 2 1 6 4 1	
PATIENT LAST NAME LAST3		PATIENT FIRST NAME FIRST3		PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #)	
DATE OF BIRTH (DD-MMM-YYYY) 02 FEB 1991		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U		MSC 2 1 6 4 1	
PATIENT ADDRESS 654 STREET NAME		CITY/TOWN CITY		PROVINCE BC	
PATIENT HOME NUMBER 250-511-1551		PATIENT CELL PHONE NUMBER 778-545-6543		POSTAL CODE V6A 0G1 MSC 2 1 6 4 1	
LANGUAGE PREFERRED ENGLISH		REFERRAL DATE (DD-MMM-YYYY) 05 MAR 2026		PROVIDER SIGNATURE	
STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy					
<p>Patients are excluded from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:</p> <ul style="list-style-type: none"> • Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required. • Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider. • Are on a definite surveillance plan through a specialist. • Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome). <p>Screening Colonoscopy (Do not order FIT for these patients) Recommended for individuals up to age 74 (inclusive), at higher than average risk.</p> <p>Family History For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.</p> <p><input checked="" type="radio"/> One first degree relative with colorectal cancer diagnosed under the age of 60; or,</p> <p><input type="radio"/> Two or more first degree relatives with colorectal cancer diagnosed at any age; or,</p> <p>Personal History <input type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)</p> <p>Colonoscopy for Abnormal FIT (for individuals ages 50-74 only) <input type="radio"/> Abnormal FIT Result date: (DD-MMM-YYYY) _____</p> <p><input checked="" type="radio"/> DUE NOW</p> <p><input type="radio"/> DUE: _____ (MMM-YYYY)</p>					
<p>For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)</p> <p><input type="radio"/> Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required). Planned Procedure Date: (DD-MMM-YYYY) _____ Endoscopy Unit: _____</p> <p>Select at least one indication: <input type="radio"/> Abnormal FIT <input type="radio"/> Personal Hx of Adenomas <input type="radio"/> FHx (1st Degree relative < 60 y.o.) <input type="radio"/> FHx (2+ 1st Degree relatives)</p>					
STEP 3 Fax Form to BC Cancer Colon Screening: 1-604-297-9340					
<p>Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.</p> <p>Facsimile communications are intended only for the use of the addressee and may contain information that is privileged and confidential. Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited. If you receive this communication in error, please notify the Colon Screening Program immediately by telephone at 1-877-702-6566.</p> <p style="text-align: right;">20840</p>					
Co007 – Jan 2026					

Appendix C

Primary Care Provider referral example for a patient who is 64 years of age with a personal history of adenoma(s), who is due May 2027 based on their colonoscopy that occurred outside of the Colon Screening Program in May 2022. This patient will be registered into the program and a referral will be sent to their local health authority and their Primary Care Provider when they are due in 2027.

BC CANCER COLON SCREENING Provincial Health Services Authority			Colon Screening Program: Colonoscopy Referral Form		
STEP 1 Complete Provider and Patient Information					
PHN NUMBER 9123456789		OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)		ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE MSC 1 2 3 1 2	
PATIENT LAST NAME LAST1		PATIENT FIRST NAME FIRST1		PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE MSC 1 2 3 1 2	
DATE OF BIRTH (DD-MMM-YYYY) 07 JAN 1962		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U			
PATIENT ADDRESS 789 STREETNAME		CITY/TOWN CITY		PROVINCE BC	
PATIENT HOME NUMBER 778-545-9966		PATIENT CELL PHONE NUMBER 604-123-4568		POSTAL CODE V1A2B6	
LANGUAGE PREFERRED FRENCH		REFERRAL DATE (DD-MMM-YYYY) 05 MAR 2026		PROVIDER SIGNATURE	
STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy					
<p>Patients are excluded from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:</p> <ul style="list-style-type: none"> Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required. Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider. Are on a definite surveillance plan through a specialist. Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome). <p>Screening Colonoscopy (Do not order FIT for these patients) Recommended for individuals up to age 74 (inclusive), at higher than average risk.</p> <p>Family History For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.</p> <p><input type="radio"/> One first degree relative with colorectal cancer diagnosed under the age of 60; or, <input type="radio"/> Two or more first degree relatives with colorectal cancer diagnosed at any age; or,</p> <p>Personal History <input checked="" type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)</p> <p>Screening Colonoscopy for Abnormal FIT (for individuals ages 50-74 only) <input type="radio"/> Abnormal FIT Result date: _____ (DD-MMM-YYYY)</p> <p><input type="radio"/> DUE NOW <input checked="" type="radio"/> DUE: M A Y 2 0 2 7 (MMM-YYYY)</p> <p>For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy) <input type="radio"/> Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required). Planned Procedure Date: _____ (DD-MMM-YYYY) Endoscopy Unit: _____ Select at least one indication: <input type="radio"/> Abnormal FIT <input type="radio"/> Personal Hx of Adenomas <input type="radio"/> FHx (1st Degree relative < 60 y.o.) <input type="radio"/> FHx (2+ 1st Degree relatives)</p>					
STEP 3 Fax Form to BC Cancer Colon Screening: 1-604-297-9340					
<p>Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.</p> <p>Facsimile communications are intended only for the use of the addressee and may contain information that is privileged and confidential. Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited. If you receive this communication in error, please notify the Colon Screening Program immediately by telephone at 1-877-702-6566.</p> <p>20840</p> <p>Co007 – Jan 2026</p>					

Appendix D

Patient was referred to a specialist office due to an abnormal FIT result. The Specialist recognizes that the patient meets the Colon Screening Program eligibility criteria and discusses registering the patient in the program at the time of the specialist consult/pre-colonoscopy assessment. The specialist books the patient for colonoscopy on March 3rd, 2026. The specialists' office sends the colonoscopy referral form to the Colon Screening Program. The Program will notify the Health Authority staff that a patient has been booked for colonoscopy. The colonoscopist completes a Colonoscopy Reporting Form (see Appendix F) on the day of the colonoscopy and sends it to the Colon Screening Program. The Health Authority staff will check after the procedure is complete for pathology and will document the follow-up recommendations.


BC CAN CER COLON SCREENING Provincial Health Services Authority			Colon Screening Program: Colonoscopy Referral Form		
STEP 1 Complete Provider and Patient Information					
PHN NUMBER 9123456789		OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)		ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #) DR. COLONOSCOPIST MSC 1 2 3 4 5	
PATIENT LAST NAME LAST4		PATIENT FIRST NAME FIRST4		PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE MSC 6 5 4 3 2	
DATE OF BIRTH (DD-MMM-YYYY) 07 JAN 1962		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U		PROVIDER SIGNATURE	
PATIENT ADDRESS 789 STREETNAME		CITY/TOWN CITY		PROVINCE BC	
PATIENT HOME NUMBER 778-545-9977		PATIENT CELL PHONE NUMBER 604-123-4569		POSTAL CODE V1A2B6	
LANGUAGE PREFERRED FRENCH		REFERRAL DATE (DD-MMM-YYYY) 12 MAR 2026			
STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy					
Patients are excluded from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:					
<ul style="list-style-type: none"> • Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required. • Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider. • Are on a definite surveillance plan through a specialist. • Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome). 					
Screening Colonoscopy (Do not order FIT for these patients)					
Recommended for individuals up to age 74 (inclusive), at higher than average risk.					
Family History					
For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.					
<input type="radio"/> One first degree relative with colorectal cancer diagnosed under the age of 60; or, <input type="radio"/> Two or more first degree relatives with colorectal cancer diagnosed at any age; or, <input type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)					
<input type="radio"/> DUE NOW <input type="radio"/> DUE: _____ (MMM-YYYY)					
Personal History					
<input type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)					
Colonoscopy for Abnormal FIT (for individuals ages 50-74 only)					
<input type="radio"/> Abnormal FIT Result date: _____ (DD-MMM-YYYY)					
For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)					
<input checked="" type="radio"/> Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required). Planned Procedure Date: 0 3 M A R 2 0 2 6 (DD-MMM-YYYY) Endoscopy Unit: Royal Columbian Hospital					
Select at least one indication:					
<input type="radio"/> Abnormal FIT <input checked="" type="radio"/> Personal Hx of Adenomas <input type="radio"/> FHx (1st Degree relative < 60 y.o.) <input type="radio"/> FHx (2+ 1st Degree relatives)					
STEP 3 Fax Form to BC Cancer Colon Screening: 1-604-297-9340					
Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.					
Facsimile communications are intended only for the use of the addressee and may contain information that is privileged and confidential. Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited. If you receive this communication in error, please notify the Colon Screening Program immediately by telephone at 1-877-702-6566.					
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Appendix E

Colonoscopist referral example for a patient who is 63 years of age with a personal history of adenoma(s), who is due August 2030 based on their colonoscopy that occurred outside of the Colon Screening Program in August 2025. This patient will be registered into the program and a referral will be sent to their local health authority and their Primary Care Provider when they are due in 2030.

BC CAN CER COLON SCREENING Provincial Health Services Authority			Colon Screening Program: Colonoscopy Referral Form		
STEP 1 Complete Provider and Patient Information					
PHN NUMBER 9123456789		OTHER HEALTH NUMBER (E.G. REFUGEE, MILITARY)		ORDERING PROVIDER (NAME, ADDRESS, MSC PRACTITIONER #) DR. COLONOSCOPIST	
PATIENT LAST NAME LAST6		PATIENT FIRST NAME FIRST6		MSC 1 2 3 4 5	
DATE OF BIRTH (DD-MMM-YYYY) 09 FEB 1963		SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> X <input type="checkbox"/> U		PRIMARY CARE PROVIDER, IF DIFFERENT FROM ORDERING (NAME, ADDRESS, MSC PRACTITIONER #) DR. PRIMARY CARE	
PATIENT ADDRESS 789 STREETNAME		CITY/TOWN CITY		PROVINCE BC	
PATIENT HOME NUMBER 778-545-9988		PATIENT CELL PHONE NUMBER 604-123-4563		POSTAL CODE V1A2B7	
LANGUAGE PREFERRED FRENCH		REFERRAL DATE (DD-MMM-YYYY) 12 MAR 2026		PROVIDER SIGNATURE	
STEP 2 Confirm Eligibility and Select at Least One Indication for Colonoscopy					
<p>Patients are excluded from the Colon Screening Program (screening colonoscopy and fecal immunochemical test [FIT]) if they:</p> <ul style="list-style-type: none"> • Currently have symptoms (e.g. rectal bleeding, persistent change in bowel habits, abdominal pain, or unexplained weight loss). These individuals should be referred to a specialist, no FIT required. • Have a personal history of colorectal cancer, ulcerative colitis or Crohn's disease. These individuals should continue to obtain care through their specialist or health care provider. • Are on a definite surveillance plan through a specialist. • Documented genetic mutation predisposing to colon cancer (e.g. Lynch Syndrome). 					
<p>Screening Colonoscopy (Do not order FIT for these patients) Recommended for individuals up to age 74 (inclusive), at higher than average risk.</p> <p><u>Family History</u> For those with a family history of colon cancer the first screening colonoscopy should be done at age 40 or 10 years younger than the age of diagnosis of the youngest affected relative - whichever is earliest.</p> <p><input type="radio"/> One first degree relative with colorectal cancer diagnosed under the age of 60; or, <input type="radio"/> Two or more first degree relatives with colorectal cancer diagnosed at any age; or,</p> <p><u>Personal History</u> <input checked="" type="radio"/> A personal history of adenoma(s), sessile serrated lesion(s) or traditional serrated adenoma(s)</p> <p>Colonoscopy for Abnormal FIT (for individuals ages 50-74 only) <input type="radio"/> Abnormal FIT Result date: (DD-MMM-YYYY) _____</p>					
<p><input type="radio"/> DUE NOW <input checked="" type="radio"/> DUE: A U G 2 0 3 0 (MMM-YYYY)</p>					
<p>For COLONOSCOPISTS ONLY (Complete Colonoscopy Reporting Form [CRF] at time of colonoscopy)</p> <p><input type="radio"/> Register patient into Colon Screening Program. Patient booked/had colonoscopy (No pre-colonoscopy assessment required). Planned Procedure Date: (DD-MMM-YYYY) _____ Endoscopy Unit: _____</p> <p>Select at least one indication: <input type="radio"/> Abnormal FIT <input type="radio"/> Personal Hx of Adenomas <input type="radio"/> FHx (1st Degree relative < 60 y.o.) <input type="radio"/> FHx (2+ 1st Degree relatives)</p>					
STEP 3 Fax Form to BC Cancer Colon Screening: 1-604-297-9340					
<p>Patients will be contacted by their Health Authority to arrange an assessment for colonoscopy when required.</p> <p>Facsimile communications are intended only for the use of the addressee and may contain information that is privileged and confidential. Any dissemination, distribution or copying of this communication by unauthorized individuals is strictly prohibited. If you receive this communication in error, please notify the Colon Screening Program immediately by telephone at 1-877-702-6566.</p>					
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Appendix F Colonoscopy Reporting Form



**COLONOSCOPY
REPORTING FORM**

Provincial Health Services Authority

PRESS FIRMLY TO ENSURE LEGIBILITY FOR MULTIPLE COPIES
FAX TOP COPY TO COLON SCREENING PROGRAM: 1 (604) 297 9340
GREY SECTIONS TO BE COMPLETED AS REQUIRED

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

03 MAR 2026 <small>EXAM DATE (DD-MMM-YYYY)</small>	0 8 3 5 <small>START TIME (HRS)</small>	LAST4 <small>PATIENT NAME LAST</small>	FIRST4 <small>PATIENT NAME FIRST</small>	F <small>SEX (F/M/X/U)</small>
ROYAL COLUMBIAN HOSPITAL <small>FACILITY NAME</small>	 <small>AMENDED DATE (DD-MMM-YYYY)</small>	9123456789 <small>PHN</small>	07 JAN 1962 <small>DATE OF BIRTH (DD-MMM-YYYY)</small>	
12345 <small>COLONOSCOPIST (MSC)</small>	DR. COLONOSCOPIST <small>COLONOSCOPIST LAST, FIRST</small>	65432 <small>PRIMARY PROVIDER (MSC)</small>	DR. PRIMARY CARE <small>PRIMARY PROVIDER LAST, FIRST</small>	

Reason Colonoscopy did not occur (select one):

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)

3. UNPLANNED EVENTS None

Perforation Admit to hospital
 Bleeding Reversal agents
 Cardiovascular Death
 Respiratory Other (specify): _____

2. CECAL INTUBATION (or ileocolonic anastomosis reached)

Yes → Photo documentation? No Yes
 No Uncertain Flexible Sigmoidoscopy

4. SPECIMENS TAKEN: Yes No → **WITHDRAWAL TIME:** 17
(Minutes)

5. COMMENTS TO PATHOLOGIST:

	Specimen Type	Location	Size (mm)				Morphology	Primary Removal Mode	Submucosal Injection (Y/N)	Piecemeal (Y/N)	Complete Removal (Y/N/U)	Complete Retrieval (Y/N/U)	Specimen Sent (Y/N/U)	Time	Initials
			≤5	6-9	10-19	≥20									
Example	P	T		✓			P	HS	Y	Y	Y	Y	Y	14:00	AB
1/A															
2/B															
3/C															
4/D															
5/E															

6. Additional specimens recorded on Page 2

7. Repeat Colonoscopy Required
COMPLETE COLONOSCOPY REPORTING FORM FOR NEXT SCOPE

Specimen Type	Location	Morphology	Removal Mode
B = biopsy P = polypectomy	A = ascending colon C = cecum D = descending I = ileum L = left colon O = other/random R = rectum S = sigmoid T = transverse colon	F = flat M = mass O = other P = pedunculated S = sessile	BF = biopsy forceps CS = cold snare HB = hot biopsy forceps HS = hot snare
Y = yes N = no U = uncertain			

MD NAME: _____ SIGNATURE: _____ RN NAME: _____ SIGNATURE: _____

SEND COPIES OF PATHOLOGY REPORT TO:


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

Specimen tracking required by facility? Number of samples sent to collection area: _____ INITIALS _____ DATE: _____
 No Yes → Number of samples transported to lab: _____ INITIALS _____ DATE: _____
 Number of samples received by lab: _____ INITIALS _____ DATE: _____

PATHOLOGY COPY | FAX THIS COPY TO 1 (604) 297 9340

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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Appendix G

Colon Screening Program Patient Referral Pathway Flow Diagram

Colon Screening Program Patient Referral Pathway

Colon Screening Program: Colonoscopy Referral Form

STEP 1 - Complete Provider and Patient Information

STEP 2 - Confirm Eligibility and Select at Least One Indication for Colonoscopy

STEP 3 - Fax Form to BC Cancer Colon Screening: 1-604-297-9340

The Colonoscopy Referral Form can be completed by either a Health Care Provider or a Colonoscopist. Each type of provider should request a referral according to the below options:

- PATIENT & PROVIDER INFORMATION**
 - The patient's mailing address will determine the local health authority the patient will be referred to.
 - The primary care provider listed will receive notifications regarding the patient's follow up recommendation.
- REASON FOR REFERRAL**

HEALTH CARE PROVIDER AND/OR COLONOSCOPIST

 - Indicate reason(s) for referral.
 - Indicate one of DUE NOW or DUE at a future date.

COLONOSCOPIST ONLY

If the patient was referred directly to your office and you would like them to be followed by the Colon Screening Program:

 - Indicate the date of procedure and endoscopy unit.
 - Indicate reason(s) for referral.

Colonoscopists should complete a Colonoscopy Reporting Form at the time of the colonoscopy.

Document Change Guide

Date	Version	Type of Change	Change Made	Pages Affected/Location
20211210	December 2021	New document guide	New document guide	All
20220407	April 2022	Added Appendix A, B	Added new referral examples for 1 FDR and 2 FDR referrals	8, 9
20220303	March 2026	Document updates Added Appendix F, G	Updated Colonoscopy Referral Form Sample image. Changed Primary Care Provider section to Primary Care Provider and/or Colonoscopists. Updated image on Primary Care Provider and/or Colonoscopists section. Updated statement under Planned Procedure Date Amended Appendix E. Added Appendix F: colonoscopist referring patient for a future recall. Added Appendix G: Patient Referral Pathway Flow Diagram	4, 6, 7, 13-15