

## Colonoscopy Report

### When to use this form

This form is to be completed by a Colonoscopist when a National Bowel Cancer Screening Program (the Program) participant with a positive FOBT result has been referred for colonoscopy.

### Instructions

The form is presented in seven (7) sections. All sections must be completed. Once completed please:

- lodge the form by free fax to **1800 115 062** or mail to: NBCSP Register, Reply Paid 83061, Hobart TAS 7001;
- provide a copy to the referring Medical Practitioner; and
- retain a copy for your records.

### Information payment

An information payment will be made for providing information on this form to the Register. In order to receive an information payment, you must complete (once only for each provider location) a **Payment Account Details for Service Provider** form to identify the bank account for receipt of payments from Medicare Australia. This form is available on the Program website at [www.cancerscreening.gov.au](http://www.cancerscreening.gov.au)

### Re-ordering details

An electronic version of this form is available on the Program website at [www.cancerscreening.gov.au](http://www.cancerscreening.gov.au) which can be completed on your computer and submitted via a secure internet connection. The website also has a link to download a copy of a paper based form that can be completed by hand and sent to the Register by facsimile or by mail.

Paper copies of this form can be obtained by contacting the National Bowel Cancer Screening Program **Information Line** on **1800 118 868**.

### Privacy note and acknowledgement

When joining the Program, all participants are required to sign a consent and declaration statement agreeing to their personal and clinical details being collected and provided to the Register by any health professional providing treatment under the Program.

Information provided on this form and results of tests provided under the Program will be recorded on the Register by Medicare Australia. This information will be used for reporting and follow-up of medical results, evaluating the Program and sending invitations to screen and re-screen. Information kept on the Register is protected by law and will not be released to any other person or organisation except in accordance with the *Privacy Act*.

**If you have any concerns or if anything is unclear about the Program or in this form please contact the National Bowel Cancer Screening Program Information Line on 1800 118 868 or visit the website at [www.cancerscreening.gov.au](http://www.cancerscreening.gov.au)**



# Colonoscopy Report

## 1 Patient details

Medicare/DVA number

Family name

Given name(s)

Date of birth  /  /  Gender: Female  Male

Private patient  Public patient

## 2 Risk assessment/management

### Sedation risk

Anaesthetic class:

**Class 1**

Patient has no organic, physiological, biochemical or psychiatric disturbance. The pathological process for which an operation is to be performed is localised and does not entail systemic disturbance.

**Class 2**

Mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes.

**Class 3**

Severe, systemic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality.

**Class 4**

Severe, systemic disorders that are already life threatening, not always correctable by operation.

## 3 Sedation used

- No sedation
- Conscious sedation  (patient responds to command or light prodding)
- Deep sedation  (patient only responds to repeated tactile stimulation or noxious stimulation)
- General anaesthesia  (patient does not respond to noxious stimulation)

### Who performed the sedation?

- Colonoscopist
- GP
- Nurse
- Anaesthetist

## 4 Colonoscopy result

### 4.1 Quality of bowel preparation

*In your opinion was the examination compromised by poor bowel preparation?*

Yes  No

### 4.2 Depth of insertion

	TI	CAEC	ASC	HEP	TRAN	SPLN	DESC	SIG	RECT
<b>Visualisation</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		Ileocaecal valve	<input type="checkbox"/>		Tripartite caecal folds	<input type="checkbox"/>			
		Appendiceal orifice	<input type="checkbox"/>		Terminal ileum	<input type="checkbox"/>			
<b>Documentation</b>		Terminal ileum biopsy and/or photograph	<input type="checkbox"/>			<input type="checkbox"/>			
		Caecal photograph	<input type="checkbox"/>		None	<input type="checkbox"/>			

### 4.3 Colonoscopy withdrawal time

Withdrawal Time   minutes

(Time taken from the commencement of withdrawal from most proximal point to withdrawal from the anus)

### 4.4 Abnormality found at colonoscopy

*Was any abnormality found at colonoscopy?*

Yes  No   go to section 5

### 4.5 Suspected cancer/s found at colonoscopy

*Were any suspected cancer/s found at colonoscopy?*

Yes  No



Number of suspected cancers  Biopsy taken Yes  No

(To be completed for the two (2) most advanced suspected cancers)

<b>No. 1 Site</b>	<b>CAEC</b> <input type="checkbox"/>	<b>ASC</b> <input type="checkbox"/>	<b>HEP</b> <input type="checkbox"/>	<b>TRAN</b> <input type="checkbox"/>	<b>SPLN</b> <input type="checkbox"/>	<b>DESC</b> <input type="checkbox"/>	<b>SIG</b> <input type="checkbox"/>	<b>RECT</b> <input type="checkbox"/>
<b>No. 2 Site</b>	<b>CAEC</b> <input type="checkbox"/>	<b>ASC</b> <input type="checkbox"/>	<b>HEP</b> <input type="checkbox"/>	<b>TRAN</b> <input type="checkbox"/>	<b>SPLN</b> <input type="checkbox"/>	<b>DESC</b> <input type="checkbox"/>	<b>SIG</b> <input type="checkbox"/>	<b>RECT</b> <input type="checkbox"/>

### 4.6 Information on polyps found at colonoscopy

Number of polyp/s found  (eg 0, 1, 2, 3...)

Number of polyp/s removed  Number of polyp/s sent for histology

#### Data on largest (most advanced) polyp

\*Est size  (mm)

\*Size is estimated in situ by colonoscopist, preferably against open biopsy forceps.

<b>Site</b>	<b>CAEC</b> <input type="checkbox"/>	<b>ASC</b> <input type="checkbox"/>	<b>HEP</b> <input type="checkbox"/>	<b>TRAN</b> <input type="checkbox"/>	<b>SPLN</b> <input type="checkbox"/>	<b>DESC</b> <input type="checkbox"/>	<b>SIG</b> <input type="checkbox"/>	<b>RECT</b> <input type="checkbox"/>
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### 4.7 Other diagnoses at colonoscopy

Haemorrhoids  Diverticular disease

Inflammatory bowel disease  Other (please specify)

## Plans to perform another procedure

**5** Do you intend to re-examine in the near future (i.e. < 6 months)?

Yes  No



**Is this because:**

(a) bowel preparation was inadequate?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(b) examination was incomplete?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
(c) need to review the polypectomy site?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

(Tick all that are applicable)

<b>Planned procedure for re-examination</b>	Repeat colonoscopy	<input type="checkbox"/>
	CT colonography	<input type="checkbox"/>
	Double contrast barium enema	<input type="checkbox"/>
	Sigmoidoscopy	<input type="checkbox"/>

## **6** Clinician/Proceduralist details

Facility/Hospital Provider number

Name of Facility/Hospital

Clinician/Proceduralist Provider number

Name of Clinician/Proceduralist

Provider number for payment

(If same as Clinician/Proceduralist number please leave blank)

Contact number of authorising clinician who completed this form

Date of procedure

## **7** Adverse event details

**Was there an adverse event during the procedure or prior to discharge?** Yes  No

If **No**, please complete a *Procedure Report – Adverse Outcomes* form where there is an adverse event that occurs after the patient is discharged and within 30 days of the procedure. This form is available electronically or in paper form.

If **Yes**, please complete the following:

<b>Adverse outcomes:</b>	Bleeding <input type="checkbox"/>	Infection/sepsis <input type="checkbox"/>	Perforation <input type="checkbox"/>
	Reaction to Sedation <input type="checkbox"/>	Death <input type="checkbox"/>	Other <input type="checkbox"/>
Delayed Discharge	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Surgery Required	Yes <input type="checkbox"/> No <input type="checkbox"/>		

**Please attach a National Bowel Cancer Screening Program participant sticker (provided in your information kit) to the referral report and/or specimen jar prior to sending to pathology. This sticker will identify your patient as a Program participant and act as a prompt for the Pathologist to complete the Program's Histopathology Report.**