



Procedure Report – Adverse Outcomes

When to use this form

This form to be completed for an adverse outcome in relation to a Colonoscopy, Double Contrast Barium Enema, Flexible Sigmoidoscopy or CT Colonography, or any other relevant procedure relating to diagnostic investigation of a National Bowel Cancer Screening Program (Program) participant who has received a positive FOBT result.

Instructions

The form is presented in four (4) 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.

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

Re-ordering details

If you require additional copies of this form please contact the National Bowel Cancer Screening Program **Information Line** on **1800 118 868**.

Privacy note and acknowledgement

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*.

Note: All Program participants are required to sign a consent and declaration statement in which they agree to their personal and clinical details being collected and provided to the Register.

If you have any concerns or if anything is unclear about the Program or 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



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1 Patient details

Medicare/DVA number

Family name

Given name(s)

Date of birth

 / /

Gender: Female Male

2 Type of procedure

Colonoscopy Surgery CT colonoscopy

Double contrast barium enema Sigmoidoscopy

3 Adverse outcomes

Bleeding Infection/sepsis Perforation Reaction to sedation

Death Other (please specify)

Delayed discharge Yes No

Unplanned hospital admission within 30 days of procedure Yes No

Surgery required Yes No

4 Provider details

Facility/Hospital Provider number

Name of Facility/Hospital

Clinician/Proceduralist Provider number

Name of Clinician/Proceduralist

Date of procedure

 / /

Provider number for payment (if paying Clinician leave blank)

Contact number of Authorising Clinician
who completed this form

Please estimate the time
taken to complete this form.
Include the time taken to
collect any information.

Hrs

Mns