# COLONOSCOPY REPORTING FORM

BC CANCER COLON SCREENING
Provincial Health Services Authority

DO NOT PLACE LABEL ABOVE LINE

AFFIX CLIENT LABEL HERE

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

EXAM DATE (YYYYMMDD) | START TIME (HRS) | PHN | DATE OF BIRTH (YYYYMMDD)

FACILITY NAME | AMENDED DATE (YYYYMMDD) | PATIENT NAME LAST | PATIENT NAME FIRST | SEX (M/F/X)

COLONOSCOPIST (MSC) | COLONOSCOPIST LAST, FIRST | PRIMARY PROVIDER (MSC) | PRIMARY PROVIDER LAST, FIRST

Reason for Colonoscopy (select one):
☐ FIT ☐ Family History ☐ Surveillance ☐ Deviation

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:** ____ **(Minutes)**

**5. COMMENTS TO PATHOLOGIST:**

| | Specimen Type | Location | Size(mm) ≤5 | 6-9 | 10-19 | ≥20 | 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/#) | Time | Initials |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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**
B = biopsies
P = polypectomy

Y = yes N = no
U = uncertain

**Location**
A = ascending colon
C = cecum D = descending
I = ileum L = left colon
O = other/random
R = rectum S = sigmoid
T = transverse colon

**Morphology**
F = flat
M = mass
O = other
P = pedunculated
S = sessile

**Removal Mode**
BF = biopsy forceps
CS = cold snare
HB = hot biopsy forceps
HS = hot snare

**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?
☐ No ☐ Yes →

Number of samples sent to collection area: ____ INITIALS ____ DATE: ____
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

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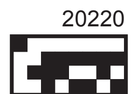

Appendix 1 to: Tomaszewski M, Sanders D, Enns R, et al. Risks associated with colonoscopy in a population-based colon screening program: an observational cohort study. *CMAJ Open* 2021. doi:10.9778/cmajo.20200192. Copyright © 2021 The Author(s) or their employer(s).
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BC CANCER COLON SCREENING
Provincial Health Services Authority

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GREY SECTIONS TO BE COMPLETED AS REQUIRED

EXAM DATE (YYYYMMDD) ______ START TIME (HRS) ______ PHN ______ DATE OF BIRTH (YYYYMMDD) ______

FACILITY NAME ______ AMENDED DATE (YYYYMMDD) ______ PATIENT NAME LAST ______ PATIENT NAME FIRST ______ SEX (M/F/X) ______

COLONOSCOPIST (MSC) ______ COLONOSCOPIST LAST, FIRST ______ PRIMARY PROVIDER (MSC) ______ PRIMARY PROVIDER LAST, FIRST ______

Reason for Colonoscopy (select one):
☐ FIT ☐ Family History ☐ Surveillance ☐ Deviation

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:** ______ **(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/#) | 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**
B = biopsies
P = polypectomy

Y = yes N = no
U = uncertain

**Location**
A = ascending colon
C = cecum D = descending
I = ileum L = left colon
O = other/random
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**Morphology**
F = flat
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O = other
P = pedunculated
S = sessile

**Removal Mode**
BF = biopsy forceps
CS = cold snare
HB = hot biopsy forceps
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**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?
☐ No ☐ Yes →

Number of samples sent to collection area: ______ INITIALS ______ DATE: ______
Number of samples transported to lab: ______ INITIALS ______ DATE: ______
Number of samples received by lab: ______ INITIALS ______ DATE: ______

CHART COPY | FILE IN CHART

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Provincial Health Services Authority

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**1. BOWEL PREPARATION**

☐ Excellent ☐ Good
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☐ Poor (inadequate to visualize all polyps > 5mm)

**3. UNPLANNED EVENTS** ☐ None

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☐ 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:** ____ **(Minutes)**

**5. COMMENTS TO PATHOLOGIST:**

| | Specimen Type | Location | Size(mm) ≤5 | 6-9 | 10-19 | ≥20 | 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/#) | Time | Initials |
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| 2/B | | | | | | | | | | | | | | | |
| 3/C | | | | | | | | | | | | | | | |
| 4/D | | | | | | | | | | | | | | | |
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Fax#: 1 (604) 297 9340
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Number of samples received by lab: ____ INITIALS ____ DATE: ____

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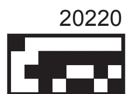

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☐ Bleeding ☐ Reversal agents
☐ Cardiovascular ☐ Death
☐ Respiratory ☐ Other **(specify):**

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

**5. COMMENTS TO PATHOLOGIST:**

| | Specimen Type | Location | Size(mm) ≤5 | Size(mm) 6-9 | Size(mm) 10-19 | Size(mm) ≥20 | 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/#) | Time | Initials |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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**
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P = polypectomy

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U = uncertain

**Location**
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HB = hot biopsy forceps
HS = hot snare

**MD NAME:** **SIGNATURE:** **RN NAME:** **SIGNATURE:**

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Fax#: 1 (604) 297 9340
2. Primary Provider (Name & MSC#)
3. Other (Name & MSC#)
4. Other (Name & MSC#)

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

COLONOSCOPIST COPY | FOR YOUR RECORDS

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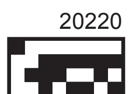

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## Colonoscopy Reporting Form Instructions for Completion of Page 1

***Note:** Optional information is in italics*

**PLEASE press firmly to ensure that all four copies of this form are legible. FAX the top copy.**

**Patient Identifiers:** A label can be used if legible and affixed in the upper right corner, otherwise complete all required fields.

**Partial Form Completion:** Medically Unfit / No Show requires partial form completion only (Patient Identifiers & Procedure Specifics)

- **No Show Patients:** Check box, Re-book patient. Complete Colonoscopy Reporting Form for next booking.
- **Medically Unfit Patients:** Select if the patient is medically unfit when they present to colonoscopy. Patient will be discharged from the Colon Screening Program.

1. **Bowel Preparation:** If the preparation is poor, choose #7 "Repeat Procedure" and rebook (< 6months is recommended)
2. **Cecal Intubation:** Photo documentation is the recommended method to record cecal intubation. Flexible sigmoidoscopy can be selected for patients undergoing flexible sigmoidoscopy for follow-up on partial removal of a high risk polyp in the distal colon.
3. **Unplanned Event:** Recorded for quality assurance purposes.
4. **Specimens Taken:** Select one of the "Yes" or "No" check boxes.

**NOTE:** Withdrawal time is in minutes for each colonoscopy in which NO intervention is performed.

5. **Comments to Pathologist:** Document additional information for the Pathologist.

**Specimen Table:** (as described by column moving from left to right of the table)

- **Specimen Container:** Uniquely identified as either "1" or "A", etc. and adapts to lab specimen container sequencing based on lab or HA requirements.
- **Specimen Type:** Requires a single letter from the legend and is either a (B) biopsy or a (P) polypectomy.

**NOTE:** Random biopsies can be placed together in the same specimen container however each polyp must be placed in an individual specimen container. Choose (P) for all polyps even if removed using biopsy forceps.

- **Location:** Requires a 1 letter code entry referenced under "Location" in the legend. Choose "Other" for random biopsies.
- **Size:** Requires one check mark only in one of the four columns based on size.
- **Morphology:** Requires a 1 letter code entry referenced under "Morphology" in the legend. Choose "Other" for random biopsies.
- **Primary Removal Mode:** Requires a 2 letter code entry referenced under "Removal Mode" in the legend.
- **Submucosal Injection:** Requires a "Y" for Yes, or "N" for No entry as per the legend.
- **Piecemeal:** Requires a "Y" for Yes, or "N" for No entry as per the legend.
- **Complete Removal:** Requires a "Y" for Yes, "N" for No or "U" for Uncertain entry as per the legend.
- **Complete Retrieval:** Requires a "Y" for Yes, "N" for No or "U" for Uncertain entry as per the legend.
- **Specimen Sent:** Requires a "Y" for Yes, "N" for No as per the legend *(# is the number of pieces and is optional based on lab or HA requirements).*
- ***Time:** Optional based on individual lab or HA requirements.*
- ***Initials:** Optional based on individual lab or HA requirements.*

6. **Additional specimens recorded on Page 2:** Check this box if there are more than 5 specimens, then use the Page 2 Form.

7. **Repeat Colonoscopy Required:** Check this box if an additional colonoscopy is required due to, for example, poor bowel prep, cecum not intubated, incomplete removal of polyps. The Colonoscopist should re-book the colonoscopy and complete the Colonoscopy Reporting Form for this subsequent colonoscopy to ensure the patient remains in the Program.

**Signature:** MD Name requires the Colonoscopist to print and sign their name indicating form accuracy and completion.

**Send Copies of Pathology Report To:**

1. This copy is for BC Cancer Colon Screening and is required to ensure complete screening records are maintained.
2. List the PCP Name and MSC# to ensure that a copy of the pathology report is sent to the primary care provider

3. & 4. Document the name and MSP/billing number of any other providers that should receive a copy of the pathology report

***Chain of Custody Section:** If applicable and required by HA, document the number of samples (specimen containers) sent, transported, and received by the lab, including the initials of the person and the date for each one of these three aspects.*

----- Please complete all required information on this form to prevent it from being returned and delaying patient care -----

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