

Colon Diagnostic Form

Please Print Clearly		<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	BCCHP#:	Authorization#:
CLIENT NAME (Last, First, Mi)		DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	CHART#
PROCEDURE SITE		AGE	PROVIDER NAME	CLIENT CONTACT NUMBER
Consult Date:		Procedure Date:		
Adequate bowel prep <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No		Cecum reached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable		Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated
		Polypectomy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated		Specimens sent to pathology #
Complications:				
<input type="checkbox"/> Bleeding not requiring transfusion		<input type="checkbox"/> No complications reported		
<input type="checkbox"/> Bleeding requiring transfusion		<input type="checkbox"/> Bowel perforation		<input type="checkbox"/> Other
<input type="checkbox"/> Complications related to anesthesia		<input type="checkbox"/> Post-polypectomy syndrome/excessive abdominal pain		<input type="checkbox"/> Unknown
<input type="checkbox"/> Other finding not suggestive of cancer or polyp(s)		<input type="checkbox"/> Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc)		<input type="checkbox"/> Death
Results			Follow-up testing needed to achieve final diagnosis	
<input type="checkbox"/> Normal: Negative, diverticulosis, hemorrhoids <input type="checkbox"/> Polyp(s) not suggestive of cancer <input type="checkbox"/> Polyp(s) suspicious for cancer/ presumed cancer <input type="checkbox"/> Other finding not suggestive of cancer or polyp(s) <input type="checkbox"/> No findings/ inconclusive			<input type="checkbox"/> None = diagnosis is complete <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> DCBE <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Surgery	
Size of the largest adenomatous polyp/lesion			Total # adenomatous polyps / lesions	
<input type="checkbox"/> < 1 cm <input type="checkbox"/> ≥ 1 cm <input type="checkbox"/> unknown			# <input type="checkbox"/> exact # unknown	
Histology of most severe polyp/lesion: (check one)				
<input type="checkbox"/> Normal or other non-polyp histology		<input type="checkbox"/> Adenoma, villous (no high-grade dysplasia)		
<input type="checkbox"/> Non-adenomatous polyp (e.g.,inflammatory, hamartomatous)		<input type="checkbox"/> Adenoma, serrated (no high-grade dysplasia)		
<input type="checkbox"/> Hyperplastic polyp		<input type="checkbox"/> Adenoma with high-grade dysplasia (includes in-situ carcinoma)		
<input type="checkbox"/> Adenoma, NOS (no high-grade dysplasia noted)		<input type="checkbox"/> Adenocarcinoma, invasive		
<input type="checkbox"/> Adenoma, tubular (no high-grade dysplasia noted)		<input type="checkbox"/> Carcinoma, other		
<input type="checkbox"/> Adenoma, mixed tubular villous (no high-grade dysplasia noted)		<input type="checkbox"/> Unknown / other lesions ablated, not retrieved or confirmed		
Recommended Future Screening		Indication for Future Screening		Future Screening/Surveillance Timing
<input type="checkbox"/> DCBE <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Sigmoidoscopy		<input type="checkbox"/> Screening <input type="checkbox"/> Surveillance		# months
Provider Comments				
<input type="checkbox"/> Did not complete procedure. Why? <input type="checkbox"/> **Lost to Follow-up, did not complete procedure, date Why lost? <input type="checkbox"/> **Refused, date Why refused? ** Provide documentation to BCCHP Prime Contractor of attempts to contact client				
DIAGNOSTIC PROVIDER SIGNATURE		Print Name	Telephone Number	Date

Please FAX form to BCCHP Prime Contractor: 509-324-1599