Washington State Department of Health
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SPOKANE REGIONAL HEALTH DISTRICT
PHONE 509-323-2851 FAX 509-324-1408
WWW.SRHD.ORG

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

COLON HISTORY & SCREENING FORM

Please Print BCCHP ID# Authorization #

Last Name: First Name: MI: Date:

Date of Birth | Clinic/Screening Site: Provider:

☐ Male ☐ Female | Appt Date: Time: Clinic Chart #:

Health Insurance: ☐ No ☐ Yes: If "Yes", company: Policy/ID #: Deductible Amount: :$

MEDICAL HISTORY – determining eligibility

If "Yes" to any of the 3 questions below, ineligible for program. Refer client for services outside of BCCHP

Symptomatic for any of the following? ☐ No ☐ Yes
☐ Change in bowel habits ☐ Blood in or on the stool ☐ Severe nausea &/or vomiting
☐ Persistent lower abdominal pain ☐ Unexplained weight loss ☐ Other::

Personal history of : ☐ Ulcerative colitis ☐ Crohn's colitis ☐ No

Genetic or clinical diagnosis of a hereditary colon cancer syndrome (FAP, Lynch syndrome or HPNCC)? ☐ No ☐ Yes

MEDICAL HISTORY - determining appropriate test

May be eligible for Colonoscopy with prior authorization. See Colon Care Algorithm.

Personal history colorectal cancer? ☐ No ☐ Yes *Year diagnosed:*
Personal history polyp(s)? ☐ No ☐ Yes; polyp type: ☐ Unknown ☐ Benign ☐ Adenoma; # polyps: Largest polyp (mm)
Family history of colorectal cancer or pre-cancerous polyps in a First-degree relative *(parent, sibling or child)*?* ☐ No ☐ Yes ☐ Unknown
If "Yes" Which relative(s)? ☐ Parent, Age ☐ Sibling, Age ☐ Child, Age
**One First-degree relative* (parent, sibling or child) *diagnosed before the age of 60? Yes -> Refer for colonoscopy*
One First-degree relative diagnosed at age 60 or greater? Yes -> Refer for FIT/FOBT
Two or more First-degree relatives (parent, sibling or child) *diagnosed with colon cancer at any age? Yes -> Refer for colonoscopy*

SCREENING HISTORY - determining appropriate test

☐ FOBT/FIT Date:
Test Result ☐ Normal ☐ Positive

☐ Sigmoidoscopy - Date: ☐ Colonscopy - Date:
Test result: ☐ Normal ☐ Polyp, tumor, or cancer ***(Obtain report to determine surveillance schedule)***
☐ Incomplete ☐ Unknown

SCREENING RECOMMENDATION & RESULTS

☐ FOBT ☐ FIT ☐ FOBT/FIT Refused Date given: Date returned: ☐ *Test not returned*
☐ Colonoscopy → Refer to BCCHP to schedule Colonoscopy ☐ Colonoscopy Refused
☐ Not Indicated

FOBT/FIT Results: ☐ Negative → Annual FOBT/FIT screening ☐ **Positive** → Refer to BCCHP to schedule Colonoscopy ☐ Colonoscopy Refused
☐ Incomplete/inadequate → Repeat

Indication for Test: ☐ Screening ☐ Surveillance

Recommendations for Follow-Up:
☐ Next screening in months
☐ Follow-up with client about unreturned cards

Client Counseling/Education:
☐ Tobacco Cessation
☐ Risk factors for colorectal cancer
☐ Importance of screening exams

PROVIDER COMMENTS:

REIMBURSEMENT REQUEST FOR SERVICES

Preventive Office Services:	Office Services:	Laboratory:
☐ 99386-new client (40-64 years old)	☐ 99201-new client, problem-focused, straightforward (10 minutes)	☐ 82270-gFOBT
☐ 99387-new client (65+ years old)	☐ 99202-new client, expanded-focused, straightforward (20 minutes)	☐ 82274-iFOBT/FIT
☐ 99396-established client (40-64 years old)	☐ 99203-new client, detailed, low complexity, straightforward (30 minutes)	
☐ 99397-established client (65+ years old)	☐ 99211-established client, problem-focused, straightforward (5 minutes)	
	☐ 99212-establsihed client, expanded-focused, straightforward (10 minutes)	
	☐ 99213-establsihed patient-expanded focused, low complexity (15 minutes)	
	☐ 99214-established patient-detailed, moderate complexity (25 min)	

DIAGNOSTIC PROVIDER SIGNATURE	Print Name	Telephone Number	Date

PLEASE FAX FORM TO BCCHP PRIME CONTRACTOR AT: 509-324-1599 Updated 10-01-2015

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY call 711).