



Assessment Form –

Referred for colonoscopy/Not referred for colonoscopy following a positive FOBT result

Background

Participants in the National Bowel Cancer Screening Program (the Program) have been sent a letter of invitation, information booklet and Faecal Occult Blood Test (FOBT) kit by the National Bowel Cancer Screening Program Register (the Register).

When to use this form

This form is to be used to provide information to the Register about consultations with Program participants who have received a positive FOBT result, including situations where:

- a participant with a positive FOBT result is referred for colonoscopy;
- it is considered inappropriate for a participant with a positive FOBT result to undergo further testing (eg where significant co-morbidities exist); or
- the participant with a positive FOBT result decides not to undergo further testing.

Instructions

The form is presented in five (5) 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;
- attach a copy to the referral letter of the treating specialist; and
- keep a copy on the patient's medical 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

Re-ordering details

If you require additional copies of this form, address labels or Program stickers, 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*.

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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ID number

(Located on the Participant's results letter)

1 Patient details

Medicare/DVA number

Family name

Given name(s)

Date of birth / / Gender: Female Male

Contact telephone number

2 Symptoms present at time of assessment following a positive FOBT result

(Mark all those that apply)

No symptoms Recent onset rectal bleeding (≤ 6 months)

Longer standing rectal bleeding (> 6 months) Significant change in bowel habits

Iron deficiency anaemia Abdominal pain

3 Assessment outcome following a positive FOBT result

<p>Referred for colonoscopy <input type="checkbox"/></p> <p>Specialist/clinic name and location</p> <input type="text"/> <input type="text"/> <input type="text"/> Postcode <p>(e.g. name of specialist and/or hospital/clinic and suburb)</p> <p>Contact telephone number</p> <input type="text"/>	<p>Not referred for colonoscopy <input type="checkbox"/></p> <p>Reason for not referring for colonoscopy:</p> <p>Bowel cancer previously diagnosed <input type="checkbox"/></p> <p>Limited life expectancy <input type="checkbox"/></p> <p>Recent colonoscopy (< 18 months) <input type="checkbox"/></p> <p>Patient declines colonoscopy <input type="checkbox"/></p> <p>Significant co-morbidity <input type="checkbox"/></p> <p>Other medical condition/s <input type="checkbox"/></p>
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4 Referred for other examination (If Yes, indicate which examination:)

No Yes → Double contrast barium enema Sigmoidoscopy

CT colonography Other (please specify)

5 Provider details

Provider number for payment

Name

Date of consultation / /

Consent statement: I have discussed the provision of this information with the patient and obtained consent to provide it to the Register.

Signed Dated / /

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

Hrs	Mns
<input type="text"/>	<input type="text"/>

If you are referring your patient for colonoscopy, please attach a National Bowel Cancer Screening Program participant sticker (provided in your information kit) to the colonoscopy referral letter. This sticker will identify your patient as a Program participant and act as a prompt for the specialist to complete the Program's Colonoscopy Report.