



This report provides valuable information to the National Cancer Screening Register (Register) about your patient, where they are a National Bowel Cancer Screening Program (Program) participant. Your assistance is sought to ensure Program information is complete.

## When to use this report

This report is to provide information to the Register where your patient is a Program participant and has received a positive FOBT test result.

## Instructions for using this report

Please use a black pen and write in BLOCK LETTERS in the boxes provided.

Mandatory fields are marked with an asterisk (\*).

In Section 3, the mandatory fields only apply to the segment checked.

Preferred fields are marked with a plus (+).

## How to lodge the report

The original copy of the report can be lodged with the Register:

via free fax to 1800 115 062; or

post to National Bowel Cancer Screening Program, Reply Paid 90965, Sunshine, VIC 3020

## More information

More information about this report can be obtained by contacting the National Bowel Cancer Screening Program Contact Centre on 1800 118 868 (free call).

## Participant Privacy

### NBCSP Participant Privacy

In accordance with the relevant requirements of the *Privacy Act 1988 (Cth)*, patients are made aware that healthcare providers may collect and disclose their personal information to the National Cancer Screening Register (NCSR). You are authorised to collect and disclose your patient's personal information under the *National Cancer Screening Register Act 2016*.

### NBCSP Practitioner Privacy

The NCSR is authorised to collect information under the *Privacy Act 1988 (Cth)* and the *National Cancer Screening Register Act 2016*. The NCSR collects information about you and other healthcare providers from the Department of Human Services and others for the purpose of verifying your identity and communicating with you.

The NCSR also collects information directly from you. Your personal information may be disclosed to a range of agencies or organisations, including State and Territory Health Departments, Australian Government agencies and where you have agreed or where it is authorised or required by law or court or tribunal order.

If you require information on the NCSR's privacy policy, please visit [www.ncsr.gov.au](http://www.ncsr.gov.au)





**Note:** When referring your patient for colonoscopy, please indicate that they are a Program participant to assist with reporting to the Register. If preferred, Program stickers can be obtained by calling the National Bowel Cancer Screening Program Contact Centre on 1800 118 868 (free call).

**Please use a black pen and write in BLOCK LETTERS in the boxes provided.**

### 1 Patient Details

\*Medicare/DVA number  Participant ID number   
(located on top right corner of their result letter)

\*Family name

\*Given name(s)

\*Date of birth (dd/mm/yyyy)  /  /  \*Gender Male  Female  Other

\*Address line 1

Address line 2

\*Suburb/Town/City

\*State  Postcode

**Does the patient identify as Aboriginal or Torres Strait Islander origin? (if known)**

Aboriginal  Torres Strait Islander  Aboriginal and Torres Strait Islander  Non Indigenous  Prefer not to answer

**What is the patient's country of origin? (if known)**

**What is the patient's preferred language spoken at home? (if known)**

### 2 Symptoms present at time of assessment following a positive iFOBT result

No symptoms  Recent onset rectal bleeding ( $\leq$  6 months)  Longer standing rectal bleeding ( $>$  6 months)   
Significant change in bowel habits  Iron deficiency anaemia  Abdominal pain

\* Patient's Medicare/ DVA number

**3 \*Assessment outcome following a positive iFOBT result**

Referred for colonoscopy

Specialist/medical facility name

Address line 1

Address line 2

Suburb/Town/City

State

Postcode

Telephone

**NOT referred for colonoscopy**  **Reasons for not referring for colonoscopy**

Bowel cancer previously diagnosed

Recent colonoscopy (< 24 months)

Significant co-morbidity

Limited life expectancy

Patient declined colonoscopy

Other medical condition(s)  (please specify)

**4 \*Was the patient referred for other examinations?**

No  Yes  If yes, indicate which examinations

Double contrast barium enema

Sigmoidoscopy

CT colonoscopy

Other  (please specify)

**NB:** The Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer 2017 state that participants with positive iFOBT results should have follow-up investigation unless there was a clear breach in protocol when samples were collected (e.g. menstrual blood loss close to the time of sample collection). Repeating the iFOBT test after a positive result carries the risk of a falsely negative test result on the second occasion because of low levels of bleeding from a cancer or adenoma, intermittent bleeding, or uneven distribution of blood in the stools.

**5 \*Provider details - Write your name and provider number OR place your stamp in the box. Complete the date of consultation.**

\*Family name

\*Given name

\*Date of consultation (dd/mm/yyyy)  /  /

\*Consulting Healthcare Provider number

Medicare Billing Provider number (if known, and different from the above consulting provider)

Provider stamp