FOR HEALTHCARE PROVIDERS

NATIONAL CANCER SCREENING REGISTER QUICK START GUIDE

For healthcare providers who perform colposcopy

1. What is the National Cancer Screening Register?

The National Cancer Screening Register (NCSR) is a national electronic infrastructure that collects, analyses and reports information about the screening history of participants in the National Bowel Cancer Screening Program (NBCSP) and National Cervical Screening Program (NCSP/Program).

2. What is this Quick Start Guide for?

This Quick Start Guide is to support colposcopists to complete all required fields and submit the Colposcopy and Treatment Form.

3. How do I report to the Register?

Under the National Cancer Screening Register Rules 2017, colposcopists are required to notify prescribed cervical screening information to the Chief Medical Officer within 14 days of each colposcopic episode. Notification is by submission of an Approved Form - the Colposcopy and Treatment Form.

For colposcopies performed by a Trainee under supervision, the NCSR can support separate Colposcopy and Treatment forms being submitted to the Register by both the Trainee performing the colposcopy and by the Training Supervisor.

4. Where do I find the Colposcopy and Treatment Form?

You report to the NCSR by submitting the Colposcopy and Treatment Forms via the Healthcare Provider Portal or your integrated clinical software. For more information, visit www.ncsr.gov.au/RegisterAccess.

Alternatively, you can download the Colposcopy and Treatment Form or order it in pads of 50 forms, free of charge from the National Cervical Screening Program website.

5. How do I complete the Colposcopy & Treatment Form and when do I have to submit it?

You can submit results using either:

- Directly through the Healthcare Provider Portal or you integrated clinical software. Find out more at www.ncsr.gov.au/RegisterAccess;
- Using the hard copy form ordered from the National Cervical Screening Program website: www.health.gov.au/resources/publications/national-cervical-screening-program-colposcopy-and-treatment-form.

6. Forms submitted by fax

If you are using the hard copy form, please ensure you use a black pen and write in BLOCK LETTERS in the boxes provided in the Colposcopy & Treatment Form.

Always return the Colposcopy & Treatment Form straight after completion of a colposcopy. Do not wait for the histopathology results to come back

or for treatment to take place.

If the outcome of the diagnostic colposcopy indicates that:

- no further intervention is required, only complete one form.
- further intervention is required, you will need to complete two forms.

This means the Colposcopy & Treatment Form should be completed twice for one individual if the individual is required to return for treatment.

- The first form should be completed for the diagnostic colposcopy at the time of colposcopy and submitted to the NCSR within 14 days of completion of the colposcopy.
- A second form should be completed for the treatment and submitted to the NCSR within 14 days of completion of the treatment. This form need only include the patient's details, the colposcopists details, the date of treatment and the treatment details for the episode.

The 14 days is calendar days and commences after the day the colposcopy or treatment is completed.

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Document ID: NCSR-BA-PRD-022. March 2022.

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6.1 Why do I need to write the patient's Medicare number on both pages of the form?

It is important to write the patient's Medicare number at the top of both pages of the form so that if they are separated during the faxing or scanning process, they can be correctly matched to the patient.

6.2 What if my patient doesn't have a Medicare number?

For patients who do not have a Medicare number (Medicare ineligible), on the first page, please make a note by the patient's details, that this is not applicable.

On the top of the second page, please either, clearly handwrite the patient's name and date of birth, or use a patient label with the details.

6.3 Can I photocopy and submit forms?

Please don't submit photocopied forms. The boxes on photocopied forms are lighter than the original which precludes the form from being scanned by the Optical Character Recognition (special software for optical character recognition).

When copying, do not copy both pages side by side on A4 paper. This is because Optical Character Recognition is unable to scan double copied forms, as the fields are smaller than the settings on the scanner.

If you need to photocopy blank forms, please increase the darkness of the photocopy.

6.4 Can I fax batches of forms?

Yes. If you are faxing forms to the National Cancer Screening Register in a batch, please send page one and two for the same patient before sending the next patient's form. This allows for ease of matching data and prevents a call to the practice for clarification.

6.5 Should I mail the forms to the NCSR after I have faxed them?

No. Once you have faxed a form to the NCSR, there is no need to also mail the original. Colposcopists are encouraged to keep a copy for their own records.

7. Can I report using a different form or format?

No. Colposcopies should be reported using the approved Colposcopy & Treatment form. Optical Character Recognition is unable to scan information reported in other formats.

8. Do I need to submit a Colposcopy & Treatment Form for vaginoscopies and vulvoscopies?

Colposcopies performed for reasons other than abnormal cervical screening, such as vaginoscopies and vulvoscopies, that are related to the detection and prevention of cervical cancer, should be notified.

9. If a colposcopy is performed on a woman who has had a hysterectomy, how do I document this on the form?

In the section "Colposcopy Adequacy" free text can be added to document that the woman has had a hysterectomy.

10. If the cervix is present and a lesion is found outside the TZ, is this able to be documented?

If the lesion is located outside of the TZ this can be documented in the section "Primary colposcopy impression" by selecting the box for other and writing the information in the provided boxes.

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11. Why is my biopsy rate lower than my records indicate?

There are a few reasons this may have occurred:

- Biopsies taken pre-renewal will not have a form to include in the report, in which case a follow-up colposcopy with no biopsy could be incorrectly included in the biopsy rate.
- Colposcopies that reported a Type 3 TZ were not excluded from the biopsy rate.
- A previous biopsy may be on a form which has not yet been matched to the participant's record.

16. Where can I find more information?

For more information on the National Cervical Screening Program, please visit www.health.gov.au/ncsp.

For more information on the National Cancer Screening Register, please visit www.ncsr.gov.au or contact us on **1800 627 701**.

For more information on the notification requirement for colposcopists, please visit view the Colposcopy & Treatment Form.