Australian Government

Adverse Events Report

NATIONAL BOWELCANCER SCREENING PROGRAM

When to use this form

Use this form to submit adverse events for a patient who has had a colonoscopy after a positive immunochemical faecal occult blood test (iFOBT).

Filling in this form

- Do not supply copies of internal clinical reports with this form.
- Fill in all mandatory fields marked with an asterisk (*).
- If filling in hard copy, use a black or blue pen and write in BLOCK LETTERS.

Submitting this form

Electronic	Complete this form electronically by accessing the NCSR Healthcare Provider Portal using Provider Digital Access (PRODA) at www.ncsr.gov.au/hcp-portal For assistance accessing the Healthcare Provider Portal, call **1800 627 701**. You can also book a time to receive a call back: www.ncsr.gov.au/support
Hardcopy	**Return it via:** • **Free fax:** 1800 115 062 • **Mail to:** National Bowel Cancer Screening Program Reply Paid 90965 SUNSHINE VIC 3020 If you require another form, go to www.health.gov.au/nbcsp-hcp-forms

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 NCSR. You are authorised to collect and disclose your patient's personal information under the *National Cancer Screening Register Act 2016*.

The NCSR is authorised to collect information about you and other healthcare providers from Services Australia 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.

For further information on the NCSR privacy policy, visit www.ncsr.gov.au/privacy.

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1 Patient details

Patient Medicare / DVA number *

Family name *

Given name(s) *

Date of birth * (DD/MM/YYYY) / /

2 Healthcare provider details (person completing this form)

Medicare provider number *

Family name *

Given name(s) *

3 Proceduralist details

Name of facility/ hospital *

Medicare provider number

Family name

Given name(s)

Date of procedure * (DD/MM/YYYY) / /

4 Adverse events

Was there a known adverse event as a result of the colonoscopy? * ☐ Yes ☐ No

Was there a known unplanned hospitalisation within 30 days of the colonoscopy? * ☐ Yes ☐ No

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