This Colonoscopy and Histopathology 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.

**Instructions for colonoscopists**

Step 1. Complete Sections 1 to 9a (please use codes provided when completing Section 9a). Please use a black pen and write in BLOCK LETTERS in the boxes provided.

Step 2. Provide a copy of pages 1–3 to the Register (see How to lodge the report below). Keep a copy of each page for your records.

Step 3. If you are requesting histopathology services, send page 4 to the histopathologist with the specimen/s.

**Instructions for histopathologists**

See the reverse of page 4 for instructions.

**Providing completed reports**

If a report is not complete, it cannot be entered into the Register. Should your report be incomplete, Register staff will contact you to obtain missing information.

Note: Only complete the form fields as specified. Please do not supply any internal clinical reports to the Register.

**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 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
Instructions for using this report

1. Please use a black pen and write in BLOCK LETTERS in the boxes provided.
2. Once sections 1-9a (the Colonoscopy section of this report) is complete, a copy should be submitted to the Register. Keep a copy for your records.
3. Send page 4 of the completed report with biopsies for histopathology services.
4. Sections 9b and 10 are to be completed by the histopathologist and then submitted to the Register.
5. Mandatory fields are marked with an asterisk (*).
6. Preferred fields are marked with a plus (+)

1 Patient Details

Participant ID number
*Medicare/DVA number

*Family name
*Given name

*Date of birth (dd/mm/yyyy)
Was this a public or private patient?
Private patient
Public patient

*Address line 1
Address line 2

*Suburb/Town/City
*State
*Postcode

*Gender
Male
Female
Other

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 Referring General Practitioner

Doctor’s Provider number (if known)

Doctor’s family name

Doctor’s given name

3 Sedation

Anaesthetic class
Class 1 - No organic, psychological, biochemical or psychiatric disturbances. Pathological process for which an operation is to be performed is localised and does not entail systematic disturbance.
Class 2 - Mild/moderate systematic disturbance caused either by the condition to be treated surgically or by other pathophysiological processes.
Class 3 - Severe systematic disturbance or disease from whatever cause, even though it may not be possible to define the degree of disability with finality.
Class 4 - Severe, systematic disorders that are already life threatening, not always correctable by operation.

Sedation used
No Sedation

Conscious Sedation - Patient responds to command or light tactile stimulation.
Deep Sedation - Patient only responds to repeated tactile stimulation or noxious stimulation.
General Anaesthesia - Patient does not respond to noxious stimulation.

Who performed the sedation?
Specialist anaesthetist
Non-specialist anaesthetist
Nurse
Colonoscopist
Patient

family name

Patient given

name(s)

Date of birth

(dd/mm/yyyy)

Participant ID

number

*Medicare/DVA number

4 Colonoscopy result

*4.1 Depth of insertion

Terminal ileum

Caecum

Ascending colon

Hepatic flexure

Transverse colon

Splenic flexure

Descending colon

Sigmoid colon

Rectum

Visualisation

Ileocaecal valve

Tripartite caecal folds

Appendiceal orifice

Terminal ileum

Documentation

Biopsy

Photo

None

4.2 Colonoscopy withdrawal time

Withdrawal time from caecal entry

minutes

5 Plans to perform another procedure

Procedure

Repeat colonoscopy

CT colonography

Double contrast barium enema

Sigmoidoscopy

Reasons

Please identify the reason(s) why you plan to perform another procedure.

Bowel preparation was inadequate

Need to review the polypectomy site

Examination was incomplete

Other

6 Adverse events

Was there an adverse event during the procedure or prior to discharge? Yes No

Adverse outcomes

Bleeding

Infection/sepsis

Perforation

Reaction to sedation

Death

Other

Please specify

Delayed discharge? Yes No

Surgery required? Yes No
7 Colonoscopy provider details

*Facility/Hospital Provider number

*Name of Facility / Hospital

*Consulting Colonoscopist’s Medicare provider number

Colonoscopist’s family name

Colonoscopist’s given name

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

*Date of procedure (dd/mm/yyyy)

(+) Contact telephone number (mobile or land line including area code) (for questions about this Colonoscopy report)

8 * Diagnosis at Colonoscopy

No abnormality detected

Cancer/Polyps detected

Total specimens sent for testing

Laboratory name

Other diagnoses

9a * Colonoscopic Lesions -

Please do not place specimens sent for testing from multiple sites/polyps in one pot.

Clearly label all pots with the specimen number and site.

Complete Section 9a for any cancer/polyps even if a specimen is not sent for testing.

Do not complete Section 9a for ‘No abnormality detected’ or ‘Other diagnoses’

Use the CODES for completing Section 9a

Codes for completing Section 9a

Site* Appearance

0 - Not stated or unknown
1 - Pedunculated likely benign
2 - Pedunculated possibly malignant
3 - Sessile likely benign
4 - Sessile possibly malignant
5 - Likely malignant
6 - Transverse colon
7 - Splenic flexure
8 - Sigmoid colon
9 - Rectum

*Site is repeated in Pathology Results to cover situations where no colonoscopy report has been provided.

IMPORTANT – End of Colonoscopy form.

Provide a copy of pages 1–3 to the Program Register and, if requesting histopathology services, send page 4 to the histopathologist with specimens. 9b and 10 are to be completed by the histopathologist.
**Patient details**

- Patient family name
- Patient given name(s)
- Date of birth (dd/mm/yyyy)
- Participant ID number

**Pathology results**

Where multiple specimens from the same site in the bowel have been placed in one pot, only report on the most serious specimen. Use the CODES for completing Section 9b. Please use a black pen and write in BLOCK LETTERS in the boxes provided.

<table>
<thead>
<tr>
<th>Site</th>
<th>Polyp Type</th>
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</table>

**Specimen accession number**

- *Specimen collection date (dd/mm/yyyy)*

**Pathologist’s details and accession number**

- Specimen accession number
- *Specimen collection date (dd/mm/yyyy)*
- *Approved Pathology Practitioner (APP) number*
- This is the Medicare provider number of the Pathologist authorising the clinical report.
- Pathologist’s family name
- Pathologist’s given name
- Laboratory name

**Medicare Billing Provider number**

* (if known, and different from the above consulting provider) (+) Contact telephone number (mobile or land line including area code) (for questions about this Histopathology report)

End of Histopathology form.

See overleaf for details on how to lodge the histopathology report.
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**Instructions for histopathologists completing page 4 of the report**

- Please complete all (known) Patient details and Sections 9b and 10. (Please use codes provided when completing Section 9b)
- Mandatory fields are marked with an asterisk (*). Preferred fields are marked with a plus (+).
- Please use a black pen and write in BLOCK LETTERS in the boxes provided.
- Keep a copy for your record

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