Washington State Department of Health

COLON HISTORY/EXAM/SCREENING FORM

Breast, Cervical and Colon Health Program
Saving Lives Through Early Detection

PROVIDER: ______________________ **CLINIC:** ______________________ **DOS:** __________

Client Name: **DOB:** ☐ **FEMALE** ☐ **MALE**

COLON HEALTH HISTORY

AGES 50-64

Have you ever been diagnosed with any of the following conditions?

☐ Ulcerative colitis ☐ Crohn's colitis ☐ Hereditary colon cancer syndromes such as HNPCC ☐ None

Are you here today for any of the following reasons?

Lower abdominal pain, bright red blood per rectum, marked change in bowel habits, bloody stools or unexplained weight loss ☐ Yes ☐ No

A YES RESPONSE TO ANY OF THE ABOVE QUESTIONS INDICATES THE CLIENT IS NOT ELIGIBLE FOR BCCHP SERVICES

FAMILY HISTORY / RISK ASSESSMENT: Have any of your direct relatives (your parents, siblings or children) ever been diagnosed with colorectal cancer or pre-cancerous polyps before they were age 60? OR Have two or more relatives been diagnosed with colorectal cancer at any age?

☐ Mother/Father ☐ Brother/Sister ☐ Children ☐ Two or more relatives

☐ Yes ☐ No ☐ Unknown ☐ Yes, colorectal cancer ☐ Yes, pre-cancerous polyps If **yes,** at what age were they diagnosed? __________

Have you ever been diagnosed with, or treated for colorectal cancer? ☐ Yes ☐ No ☐ Unknown If yes: Year diagnosed: __________

A YES RESPONSE TO ANY OF THE ABOVE QUESTIONS INDICATES CLIENT SHOULD BE EVALUTED BY COLONOSCOPY.

Screening History			**Date** (mm/yyyy)	**Test Result**			
☐ FOBT / FIT	☐ No	☐ Unknown	__________	☐ Normal	☐ Abnormal / positive test result	☐ Incomplete	☐ Unknown
☐ Sigmoidoscopy	☐ No	☐ Unknown	__________	☐ Normal	☐ Polyp(s), tumor(s), cancer	☐ Incomplete	☐ Unknown
☐ Colonoscopy	☐ No	☐ Unknown	__________	☐ Normal	☐ Polyp(s), tumor(s), cancer	☐ Incomplete	☐ Unknown
☐ DCBE	☐ No	☐ Unknown	__________	☐ Normal	☐ Polyp(s), tumor(s), cancer	☐ Incomplete	☐ Unknown

Personal history of polyp(s):

☐ Yes → Go to next box →

☐ No → Go to "**Test Recommended**"

Were polyps adenomatous (pre-cancerous)?:

☐ Yes } Go to **"Test Recommended"**
☐ Unknown } and mark **"Colonoscopy"**
☐ No → Go to "**Test Recommended**"

COLON EXAM / SCREENING

AGES 50-64

TEST RECOMMENDED

☐ FOBT →
☐ FIT →
☐ Colonoscopy
☐ Other:__________
☐ None / Not Indicated

FOBT / FIT Date given:

__________ (mm/dd/yyyy)

☐ Not given
☐ Refused

Return of FOBT / FIT KIT

☐ Received
☐ Did not return card
☐ Gave 2nd FOBT/FIT
Date __________

Date FOBT / FIT Returned:

__________ (mm/dd/yyyy)

Result:

☐ Negative → Re-screen next year
☐ Positive → Refer for colonoscopy
☐ Unknown ☐ Other__________

Colonoscopy (or other) Procedure scheduled:

Referred for case management or procedure: Date: __________ (mm/dd/yyyy)

Client Counseled/Taught About	Recommendations
☐ Risk of colon cancer ☐ Importance of screening exam (colon)	☐ Next colon screening due in _____ months

SERVICES BILLED

New BCCHP Client

☐ **99201** – Office brief new
☐ **99202** – Office expand new
☐ **99203** – Office detail new
☐ **99386** – Prev new age 40-64
☐ **99387** – Prev new age 65+

Established BCCHP Client

☐ **99211** – Office brief est
☐ **99212** – Office expand est
☐ **99213** – Office detail est
☐ **99396** – Prev est age 40-64
☐ **99397** – Prev est age 65+
☐ **BCCOV -** Brst, Cervical, Colon Office Visit

☐ **82270** FOBT (Occult blood test for colorectal screening) ☐ **82274** FIT (fecal immunochemical test)

PROVIDER SIGNATURE: ______________________ **Date:** __________

PLEASE PRINT NAME HERE
____

Provider Comments: ______________________

PLEASE FAX TO BCCHP PRIME CONTRACTOR: (509) 324-1408

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY 1-800-833-6388).