

Please Print Clearly

FEMALE MALE

Chart Number @ Site: _____

CLIENT NAME (Last, First, Mi)	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER
PROCEDURE SITE	AGE	PROVIDER NAME
CLIENT CONTACT NUMBER		

Provider Comments

Lost to Follow-up, did not complete procedure, date _____ Refused, date _____

Procedure Date: _____	Screening colonoscopy <input type="checkbox"/> 45378 <input type="checkbox"/> 45380 w/biopsy <input type="checkbox"/> 45381 w/directed submucosal injection <input type="checkbox"/> 45382 w/control of bleeding <input type="checkbox"/> 45383 w/ablation <input type="checkbox"/> 45384 w/polypectomy <input type="checkbox"/> 45385 w/polypectomy by snare <i>For other procedures not listed, refer to fee schedule</i>	Tissue exam by pathologist <input type="checkbox"/> 88300 Gross exam only (surgical specimen) <input type="checkbox"/> 88302 Gross and microscopic exam (level II) <input type="checkbox"/> 88304 Gross and microscopic exam (level III) <input type="checkbox"/> 88305 Gross and microscopic exam, colon, colorectal polyp biopsy (level IV) <input type="checkbox"/> 88307 Gross and microscopic exam, colon, colorectal polyp biopsy (level V) <input type="checkbox"/> 88309 Gross and microscopic exam, colon, colorectal polyp biopsy (level VI) <input type="checkbox"/> 88312 Special stains <input type="checkbox"/> 88342 Immunohistochemistry, each antibody
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Adequate bowel prep <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Cecum reached <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not applicable	Biopsy or Polypectomy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated	# of specimens sent to pathology # _____	Complications <input type="checkbox"/> 0= No complications reported <input type="checkbox"/> 1= Bleeding requiring transfusion <input type="checkbox"/> 2= Bleeding not requiring transfusion <input type="checkbox"/> 3= Cardiopulmonary events (hypotension, hypoxia, arrhythmia, etc.) <input type="checkbox"/> 4= Complications related to anesthesia <input type="checkbox"/> 5= Bowel perforation <input type="checkbox"/> 6= Post-polypectomy syndrome/excessive abdominal pain <input type="checkbox"/> 7= Death <input type="checkbox"/> 8= Other <input type="checkbox"/> 99= Unknown
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Results <input type="checkbox"/> Normal: Negative, diverticulosis, hemorrhoids <input type="checkbox"/> Polyp(s) not suggestive of cancer <input type="checkbox"/> Polyp(s) suspicious for cancer/ presumed cancer <input type="checkbox"/> Other finding not suggestive of cancer or polyp(s) <input type="checkbox"/> No findings/ inconclusive	Follow-up testing needed to achieve final diagnosis <input type="checkbox"/> None = diagnosis is complete <input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> DCBE <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Surgery
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♦ DIAGNOSTIC INFORMATION FOR ADENOMATOUS POLYPS/LESIONS

Total # adenomatous polyps / lesions

_____ (98= exact # unknown; 99= unknown)

Size of the largest adenomatous polyp/lesion

1 = < 1 mm 2 = ≥ 1 cm 9 = unknown

Histology of most severe polyp/lesion: (check one)

<input type="checkbox"/> 1 = Normal or other non-polyp histology <input type="checkbox"/> 2 = Non-adenomatous polyp (e.g., inflammatory, hamartomatous) <input type="checkbox"/> 3 = Hyperplastic polyp <input type="checkbox"/> 4 = Adenoma, NOS (no high-grade dysplasia noted) <input type="checkbox"/> 5 = Adenoma, tubular (no high-grade dysplasia noted) <input type="checkbox"/> 6 = Adenoma, mixed tubular villous (no high-grade dysplasia noted)	<input type="checkbox"/> 7 = Adenoma, villous (no high-grade dysplasia) <input type="checkbox"/> 8 = Adenoma, serrated (no high-grade dysplasia) <input type="checkbox"/> 9 = Adenoma with high-grade dysplasia (includes in-situ carcinoma) <input type="checkbox"/> 10 = Adenocarcinoma, invasive <input type="checkbox"/> 11 = Carcinoma, other <input type="checkbox"/> 99 = Unknown / other lesions ablated, not retrieved or confirmed
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Recommended Future Screening <input type="checkbox"/> FOBT <input type="checkbox"/> FIT <input type="checkbox"/> DCBE <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Sigmoidoscopy	Indication for Future Screening <input type="checkbox"/> Screening <input type="checkbox"/> Surveillance post (+) colonoscopy or surgery	Future Screening Timing # _____ months
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PROVIDER SIGNATURE _____ Date _____

PLEASE PRINT NAME HERE

PLEASE FAX TO BCCHP PRIME CONTRACTOR: (509) 667-7352