

PROVIDER: \_\_\_\_\_ CLINIC: \_\_\_\_\_ DOS: \_\_\_\_\_

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_  FEMALE  MALE

**COLON HEALTH HISTORY**

<b>AGES 50-64</b>	<p><b>Have you ever been diagnosed with any of the following conditions?</b></p> <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Crohn's colitis <input type="checkbox"/> Hereditary colon cancer syndromes such as HNPCC <input type="checkbox"/> None																
	<p><b>Are you here today for any of the following reasons?</b>            Lower abdominal pain, bright red blood per rectum, marked change in bowel habits, bloody stools or unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>A YES RESPONSE TO ANY OF THE ABOVE QUESTIONS INDICATES THE CLIENT IS <u>NOT</u> ELIGIBLE FOR BCCHP SERVICES</b></p>																
	<p><b>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? <u>OR</u> Have two or more relatives been diagnosed with colorectal cancer at any age?</b></p> <input type="checkbox"/> Mother/Father <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Children <input type="checkbox"/> Two or more relatives <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, colorectal cancer <input type="checkbox"/> Yes, pre-cancerous polyps    If <b>yes</b> , at what age were they diagnosed? _____																
	<p><b>Have you ever been diagnosed with, or treated for colorectal cancer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown    If <b>yes</b>: Year diagnosed: _____</p> <p><b>A YES RESPONSE TO ANY OF THE ABOVE QUESTIONS INDICATES CLIENT SHOULD BE EVALUTED BY COLONOSCOPY.</b></p>																
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Screening History</th> <th style="width:20%;">Date (mm/yyyy)</th> <th style="width:50%;">Test Result</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> FOBT / FIT    <input type="checkbox"/> No    <input type="checkbox"/> Unknown</td> <td>_____</td> <td><input type="checkbox"/> Normal    <input type="checkbox"/> Abnormal / positive test result    <input type="checkbox"/> Incomplete    <input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Sigmoidoscopy    <input type="checkbox"/> No    <input type="checkbox"/> Unknown</td> <td>_____</td> <td><input type="checkbox"/> Normal    <input type="checkbox"/> Polyp(s), tumor(s), cancer    <input type="checkbox"/> Incomplete    <input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> Colonoscopy    <input type="checkbox"/> No    <input type="checkbox"/> Unknown</td> <td>_____</td> <td><input type="checkbox"/> Normal    <input type="checkbox"/> Polyp(s), tumor(s), cancer    <input type="checkbox"/> Incomplete    <input type="checkbox"/> Unknown</td> </tr> <tr> <td><input type="checkbox"/> DCBE    <input type="checkbox"/> No    <input type="checkbox"/> Unknown</td> <td>_____</td> <td><input type="checkbox"/> Normal    <input type="checkbox"/> Polyp(s), tumor(s), cancer    <input type="checkbox"/> Incomplete    <input type="checkbox"/> Unknown</td> </tr> </tbody> </table>			Screening History	Date (mm/yyyy)	Test Result	<input type="checkbox"/> FOBT / FIT <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal / positive test result <input type="checkbox"/> Incomplete <input type="checkbox"/> Unknown	<input type="checkbox"/> Sigmoidoscopy <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Polyp(s), tumor(s), cancer <input type="checkbox"/> Incomplete <input type="checkbox"/> Unknown	<input type="checkbox"/> Colonoscopy <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	<input type="checkbox"/> Normal <input type="checkbox"/> Polyp(s), tumor(s), cancer <input type="checkbox"/> Incomplete <input type="checkbox"/> Unknown	<input type="checkbox"/> DCBE <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____
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<p><b>Personal history of polyp(s):</b>  <input type="checkbox"/> Yes    <b>→</b> Go to next box    <b>→</b>  <input type="checkbox"/> No    <b>→</b> Go to "Test Recommended"</p>		<p><b>Were polyps adenomatous (pre-cancerous)?:</b>  <input type="checkbox"/> Yes    <b>} Go to "Test Recommended"</b>  <input type="checkbox"/> Unknown    <b>} and mark "Colonoscopy"</b>  <input type="checkbox"/> No    <b>→ Go to "Test Recommended"</b></p>															

**COLON EXAM / SCREENING**

<b>AGES 50-64</b>	<b>TEST RECOMMENDED</b>			
	<input type="checkbox"/> FOBT <b>→</b> <input type="checkbox"/> FIT <b>→</b> <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Other: _____ <input type="checkbox"/> None / Not Indicated	<p><b>FOBT / FIT Date given:</b>            _____ ( mm/dd/yyyy)</p> <input type="checkbox"/> Not given <input type="checkbox"/> Refused	<p><b>Return of FOBT / FIT KIT</b></p> <input type="checkbox"/> Received <input type="checkbox"/> Did not return card <input type="checkbox"/> Gave 2 <sup>nd</sup> FOBT/FIT Date _____	<p><b>Date FOBT / FIT Returned:</b>            _____ (mm/dd/yyyy)</p> <p><b>Result:</b>  <input type="checkbox"/> Negative    <b>→</b> Re-screen next year  <input type="checkbox"/> Positive    <b>→</b> Refer for colonoscopy  <input type="checkbox"/> Unknown    <input type="checkbox"/> Other</p>
	<p><b>Colonoscopy (or other) Procedure scheduled:</b>            Referred for case management or procedure: Date: _____ (mm/dd/yyyy)</p>			

**Client Counseled/Taught About**

**Recommendations**

<input type="checkbox"/> Risk of colon cancer <input type="checkbox"/> Importance of screening exam (colon)	<input type="checkbox"/> Next colon screening due in _____ months
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**SERVICES BILLED**

<p><b>New BCCHP Client</b></p> <input type="checkbox"/> 99201 – Office brief new <input type="checkbox"/> 99386 – Prev new age 40-64 <input type="checkbox"/> 99202 – Office expand new <input type="checkbox"/> 99387 – Prev new age 65+ <input type="checkbox"/> 99203 – Office detail new	<p><b>Established BCCHP Client</b></p> <input type="checkbox"/> 99211 – Office brief est <input type="checkbox"/> 99396 – Prev est age 40-64 <input type="checkbox"/> 99212 – Office expand est <input type="checkbox"/> 99397 – Prev est age 65+ <input type="checkbox"/> 99213 – Office detail est <input type="checkbox"/> BCCOV - Brst, Cervical, Colon Office Visit
<hr/> <input type="checkbox"/> 82270 FOBT (Occult blood test for colorectal screening) <input type="checkbox"/> 82274 FIT (fecal immunochemical test)	

PROVIDER SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE PRINT NAME HERE

Provider Comments: \_\_\_\_\_

**PLEASE FAX TO BCCHP PRIME CONTRACTOR: \_\_\_\_\_**