Washington State Department of Health
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Public Health
Seattle & King County

Breast Cervical & Colon Health Program
401 5th Ave #1110 Seattle WA 98104
T 206-263-8176 F 206-296-0208

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

COLON HISTORY & SCREENING FORM

Please Print | **BCCHP ID#** | **Authorization #**

Last Name: | **First Name:** | **MI:** | **Date:**

Date of Birth | **Clinic/Screening Site:** | **Provider:**

Gender: ☐ Female ☐ Male ☐ Transman ☐ Transwoman ☐ Genderqueer ☐ Gender Non-Binary ☐ Agender ☐ _____

Appointment Date: | **Time:** | **Clinic Chart #:**

Health Insurance: ☐ No ☐ Yes: If "Yes", company: | Policy/ID #: | Deductible Amount: :$

MEDICAL HISTORY – determining eligibility

Note: **BCCHP focuses on colon screenings for patients of average risk. A "Yes" answer to any of the 3 questions below makes the patient ineligible for program services. Refer client for services outside of BCCHP.**

1. Symptomatic for any of the following? ☐ No ☐ Yes

☐ Significant change in bowel habits for more than 2 weeks ☐ Rectal bleeding, bloody diarrhea or blood in the stool (not due to hemorrhoids)
☐ Persistent lower abdominal pain ☐ Symptom of bowel obstruction (nausea, vomiting, severe constipation)
☐ Unexplained weight loss (10% or more of body weight)

2. Personal history of: ☐ Ulcerative colitis ☐ Crohn's colitis ☐ No

3. Genetic or clinical diagnosis of a hereditary colon cancer syndrome (FAP, Lynch syndrome or HNPCC)**?** ☐ No ☐ Yes

MEDICAL HISTORY - determining appropriate test

Personal history colorectal cancer? ☐ No ☐ Yes *Year diagnosed:*

Personal history polyp(s)? ☐ No ☐ Yes; polyp type: ☐ Unknown ☐ Benign ☐ Adenoma; # polyps: Largest polyp (mm)

Family history of colorectal cancer or pre-cancerous polyps in a first-degree relative *(parent, sibling or child)***?*** ☐ No ☐ Yes ☐ Unknown

If "Yes, which condition did first-degree relative have? Colorectal cancer ☐ No ☐ Yes **Pre-cancerous polyps** ☐ No ☐ Yes

If "Yes" Which relative(s)? ☐ Parent, Age ☐ Sibling, Age ☐ Child, Age

One First-degree relative *(parent, sibling or child)* ***diagnosed before the age of 60? Yes -> Refer for colonoscopy***

One First-degree relative diagnosed at age 60 or older? Yes -> Refer for FIT/FOBT

Two or more First-degree relatives *(parent, sibling or child)* ***diagnosed with colon cancer at any age? Yes -> Refer for colonoscopy***

SCREENING HISTORY - determining appropriate test

☐ FOBT/FIT Date:

Test Result ☐ Normal ☐ Positive

☐ Sigmoidoscopy - Date: ☐ Colonoscopy - Date:

Test result: ☐ Normal ☐ Polyp, tumor, or cancer ***(Obtain report to determine surveillance schedule)*** ☐ Incomplete ☐ Unknown

SCREENING RECOMMENDATION & RESULTS

☐ FOBT ☐ FIT ☐ FOBT/FIT Refused Date given: Date returned: ☐ ***Test not returned***

☐ Colonoscopy → Refer to BCCHP to schedule Colonoscopy ☐ Colonoscopy Refused ☐ Not Indicated

FOBT/FIT Results: ☐ Negative → Annual FOBT/FIT screening ☐ **Positive** → Refer to BCCHP to schedule Colonoscopy ☐ Colonoscopy Refused ☐ Incomplete/inadequate → Repeat

Indication for Test: ☐ Screening ☐ Surveillance

Recommendations for Follow-Up:
☐ Next screening in months
☐ Follow-up with client about unreturned cards

Client Counseling/Education:
☐ Tobacco Cessation
☐ Risk factors for colorectal cancer
☐ Importance of screening exams

PROVIDER COMMENTS:

REIMBURSEMENT REQUEST FOR SERVICES

Preventive Office Services:
☐ 99386-new client (40-64 years old)
☐ 99387-new client (65+ years old)
☐ 99396-established client (40-64 years old)
☐ 99397-established client (65+ years old)

Office Services:
☐ 99201-new client, problem-focused, straightforward (10 minutes)
☐ 99202-new client, expanded-focused, straightforward (20 minutes)
☐ 99203-new client, detailed, low complexity, straightforward (30 minutes)
☐ 99211-established client, problem-focused, straightforward (5 minutes)
☐ 99212-establsihed client, expanded-focused, straightforward (10 minutes)
☐ 99213-establsihed patient-expanded focused, low complexity (15 minutes)
☐ 99214-established patient-detailed, moderate complexity (25 min)

Laboratory:
☐ 82270-gFOBT
☐ 82274-iFOBT/FIT

DIAGNOSTIC PROVIDER SIGNATURE	Print Name	Telephone Number	Date

PLEASE FAX FORM TO BCCHP: (206) 296-0208

For persons with disabilities, this document is available on request in other formats. To submit a request, call 1-800-525-0127 (TDD/TTY call 711).