

# COLONOSCOPY REPORT:

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Date: \_\_\_\_\_

## Findings:

Normal Exam / No Polyps

Polyps Removed: (Location of polyps marked on illustration)

Other:



Based upon today's findings and current **American Cancer Society Guidelines:**

Repeat Colonoscopic Exam in \_\_\_\_\_ years: (\_\_\_\_\_)

Your **Risk-Assessment** is based upon the following categories:

- No Direct Family History
- Fam Hx: Older Age Onset Subgroup
- Fam Hx: Early Age Onset (< 60 y.o.)
- Fam Hx: Multiple Members
- Fam Hx: HNPCC (Bethesda Criteria)
- Normal Colonic Screen today
- Polyp(s) removed today: Adenomatous / Hyperplastic
- Large, higher risk polyp
- Past history: Adenomas / Colorectal Cancer
- Long-standing Inflammatory Bowel Disease

(X) \_\_\_\_\_

## Dear Physician:

- This summary can be used to **simplify your charting**. This is my final recommendation based upon patient history, colonoscopic findings, and the final pathology report.
- Your patient has been given a discharge educational form with our initial findings and recommendations.
- You should receive a dictated report directly from either Providence Hospital, or the Michigan Endoscopic Center.
- Unless there are special circumstances, your patient will be entered into our **recall system**.

**Referral Copy**

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