

# SCREENING UPDATE FORM



Please return this form **after you have seen your doctor** to:

NSW & ACT Hereditary Cancer Registry  
 Cancer Institute NSW, PO Box 825  
 Alexandria NSW 1435

<b>YOUR DETAILS:</b>	Address:
Name: .....	.....
D.O.B: ...../...../.....	.....
Phone:	
H: ( ..... ) .....	Mob: ( ..... ) .....
W: ( ..... ) .....	Email:.....

**YOUR BOWEL SPECIALIST DETAILS:**

1. Doctor's Name: .....

2. Doctor's Address: .....

3. Your **last** screening date: ...../...../.....

4. Which screening did this Doctor perform? *(Please note: not all of these may apply to you)*

Colonoscopy                       Flexible Sigmoidoscopy

Upper GI Endoscopy               Rigid Sigmoidoscopy

Other.....

5. Do you know when you are next due for this screening? Y / N

6. If yes,  
**Please fill in your next screening date: ...../...../.....**

7. If no, how often do you see this Doctor for this screening?

3 months               12 months               24 months (2 years)

6 months               18 months               36 months (3 years)

**COMMENTS / REQUESTS FOR FURTHER INFORMATION**

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**PLEASE TURN OVER TO ENTER THE DETAILS OF YOUR OTHER TREATING DOCTORS**

**YOUR OTHER TREATING DOCTOR'S DETAILS:**

1. Doctor's Name: .....
2. Doctor's Address: .....  
.....
3. Specialist Type: .....
4. Your **last** screening date: ...../...../.....
5. Which screening did this Doctor perform? (Please note: not all of these may apply to you)  
 CA125 Measurement       Faecal Occult Blood Testing (FOBT)  
 Urinalysis                       Transvaginal Ultrasonography  
 Other .....
6. Do you know when you are next due for this screening?    Y / N
7. If yes,  
**Please fill in your next screening date: ...../...../.....**
8. If no, how often do you see this Doctor for this screening?  
 3 months       12 months       24 months (2 years)  
 6 months       18 months       36 months (3 years)

**YOUR OTHER TREATING DOCTOR'S DETAILS:**

1. Doctor's Name: .....
2. Doctor's Address: .....  
.....
3. Specialist Type: .....
4. Your **last** screening date: ...../...../.....
5. Which screening did this Doctor perform? (Please note: not all of these may apply to you)  
 CA125 Measurement       Faecal Occult Blood Testing (FOBT)  
 Urinalysis                       Transvaginal Ultrasonography  
 Other .....
6. Do you know when you are next due for this screening?    Y / N
7. If yes,  
**Please fill in your next screening date: ...../...../.....**
8. If no, how often do you see this Doctor for this screening?  
 3 months       12 months       24 months (2 years)  
 6 months       18 months       36 months (3 years)