
ASSESS PATIENT FOR INCREASED OR HIGH RISK OF CRC

Approximately 1 in 10 individuals has a family history of cancer that would warrant earlier screening. In order for these patients to benefit from the preventative and risk reducing benefits of cancer screening, primary care clinicians need to collect and interpret family health history, identify next steps in management based on risk, and evaluate for CRC. The steps in Chapter 3 can help clinicians build essential knowledge and skills related to the collection, assessment, and management of cancer risk, regardless of the specific workflow in place in the office.

In order to identify patients with an increased or high risk of CRC, the clinician needs to collect family history information with enough detail to inform accurate risk assessment. It is also important that this family history data is documented in the medical record in a way that can be easily accessed and updated over time.

Family history risk assessment involves interpreting the patient's family history as well as personal history to identify red flags and patterns that may suggest predisposition to CRC and then using that information to stratify risk into average, increased, and high risk categories to inform personalized management. Risk assessment for CRC may also include looking for alarm signs and symptoms of a possible presenting cancer.

As you work through the following sections on risk assessment, visit the links to online education on the left side-bar for opportunities to practice these skills.

