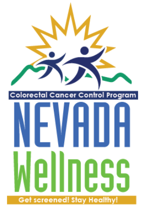
FY18

NEVADA COLORECTAL CANCER CONTROL PROGRAM (CRCCP)

IN PARTNERSHIP WITH ACCESS TO HEALTHCARE NETWORK (AHN)

Colorectal Specialty Provider Screening

Reporting Form



Last name:		First:		MI:		Birth date (mm/dd/yy):	
Clinic name & location:				Indication for initial test:	☐ Screening	☐ Surveillance	
Recommended test:	☐ FIT	☐ Colonoscopy	☐ Other:		Date of appointment or FIT kit distributed (mm/dd/yy):		

A. Fecal test information (FIT, FoBT):

Date of test (mm/dd/yy):		Fecal test result:	☐ Negative	☐ Positive	Date pt. notified of result (mm/dd/yy):	

****Complete E and F sections below**** *****Please complete additional form for tests following a positive FIT*****

B. Endoscopy information:

Date of test (mm/dd/yy):		☐ Colonoscopy	☐ Other:		Endoscopy withdrawal time:	minutes
Endoscopy facility:				**Test paid by CRCCP?**	☐ Yes	☐ No

Was bowel prep considered adequate?	☐ Yes	☐ No*	Was cecum reached?	☐ Yes	☐ No*	***An incomplete or inadequate test should be repeated**

Test is complete or adequate with (check finding):	**Test is incomplete or inadequate with** (check finding):
☐ Normal/negative	☐ No finding*
☐ Polyp	☐ Polyp*
☐ Lesion suspicious for cancer	☐ Lesion suspicious for cancer*
☐ Other finding (not polyp/cancer):	☐ Other finding* (not polyp/cancer):

***An incomplete or inadequate test should be repeated**

Was a biopsy or polypectomy performed?	☐ Yes**	☐ No	****If Yes, complete Section D after all diagnostic tests have been completed**

Complications of endoscopy requiring observation or treatment:

☐ No complications	☐ Bleeding requiring transfusion	☐ Bleeding not requiring transfusion	☐ Cardiopulmonary event
☐ Complications related to anesthesia	☐ Bowel perforation	☐ Post-polypectomy syndrome/excessive abdominal pain	☐ Death
☐ Other:			

****Complete Medical Complications Reporting Form****

C. Surgery to complete diagnosis:

Date of surgery (mm/dd/yy):		☐ Surgery recommended but not performed**	****Complete Section D**

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D. Polyp/lesion information from endoscopic biopsy or surgery: Histology of most severe polyp/lesion

☐ Normal or other non-polyp histology	☐ Adenoma, villous (no high grade dysplasia noted)
☐ Non-adenomatous polyp	☐ Adenoma, serrated (no high grade dysplasia noted)
☐ Hyperplastic polyp	☐ Adenoma with high grade dysplasia
☐ Adenoma, NOS (no high grade dysplasia noted)	☐ Adenocarcinoma, invasive
☐ Adenoma, tubular (no high grade dysplasia noted)	☐ Cancer, other
☐ Adenoma, mixed tubular villous (no high grade dysplasia noted)	☐ Unknown/other lesions ablated, not retrieved or confirmed

Adenomatous polyp/lesion information: total number of adenomatous polyps/lesions ****Complete if any of the shaded histologies above are indicated****

☐ Less than 97: enter the number ______	Size of largest adenomatous polyp/lesion: ______ mm
☐ 97 or more adenomatous polyps/lesions	☐ Adenomatous polyps removed, exact number unknown

E. Next Step

☐ Screening/diagnosis **complete** | ☐ Next screening test in ____ months ____ years | ☐ Next surveillance test in ____ months ____ years

Recommended test ☐ Colonoscopy ☐ Take-home FOBT ☐ Take-home FIT ☐ Sigmoidoscopy

☐ Non-adherence (FIT not returned/appointment cancelled) ☐ DCBE ☐ Other: ______

☐ Screening/diagnosis incomplete, additional diagnosis test needed:

☐ Sigmoidoscopy ☐ Colonoscopy ☐ DCBE ☐ Other: ______ Date scheduled: ______

F. Final Diagnosis

Date of final diagnosis (mm/dd/yy): ______ Date pt. notified of result (mm/dd/yy): ______

☐ Pending, additional tests needed	☐ Adenomatous polyp with high grade dysplasia	☐ Non-CRC cancer
☐ Normal/negative	☐ Cancer	☐ Client refused follow-up testing
☐ Hyperplastic polyp	☐ New CRC cancer	☐ Client lost to follow-up/died
☐ Adenomatous polyp, no high grade dysplasia	☐ Recurrent CRC cancer	

G. Cancer Treatment Information

*****Must be completed if Final Diagnosis = Cancer*****

Treatment started (mm/dd/yy): ______ Facility name and location: ______

☐ Treatment pending, additional tests needed	☐ Treatment not indicated due to polypectomy	☐ Treatment refused*
☐ Treatment started	☐ Treatment not recommended*	☐ Lost to follow-up* (*or administrative close-out date)

*****Please submit separate Colorectal Screening Reporting Form for additional diagnostic tests performed*****

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