Evaluation of a SW Georgia Colorectal Cancer Screening Program

Data Abstraction Form
Cover Sheet

Attention
Confidential Information

Data Collectors:
- Keep completed forms in a locked file box during your shift at the clinic.
- At the end of your shift, return all forms to the Cancer Coalition.

Cancer Coalition:
- Keep all forms in a locked file cabinet.
- Remove and shred this cover sheet once medical record number and study identification number have been recorded in the crosswalk document.
- Remove and shred this cover sheet before sending to Emory study staff.

Patient’s Medical Record Number: ________________________
Evaluation of a SW Georgia Colorectal Cancer Screening Program
Data Abstraction Form

1. Abstractor Initials: ___ ___ ___
2. Date: ___/___/____ (MM/DD/YYYY)

3. Clinic Location: ______________________________ __________________________

4. Data abstraction source (check all that apply): ☐ eClinicals ☐ Misys ☐ Paper chart

Section 1: Patient Demographic Characteristics

5. Date of Birth: ___/___/____ (MM/DD/YYYY)
6. Gender: ☐ Male ☐ Female
7. Insurance Status: ☐ Medicare
   Check all that apply
   ☐ Medicaid (e.g., Peachstate health plan)
   ☐ Private insurance
   ☐ Sliding fee scale eligible (i.e., Sliding fee “A-D” scale)

8. Race
   ☐ African American/Black ☐ Caucasian/White
   Check all that apply
   ☐ Asian/Pacific Islander ☐ American Indian/Alaska Native
   ☐ Hispanic

9. Marital status
   ☐ Never Married ☐ Divorced/Separated
   ☐ Married ☐ Widowed

10. Zipcode of current residence: __ __ __ __
Section 2: Colorectal Cancer History

**PRIOR TO NOVEMBER 1, 2009, DID THE PATIENT HAVE:**

11. ☐ Colorectal cancer ☐ Yes ☐ No
12. ☐ Colorectal Polyps ☐ Yes ☐ No
13. ☐ Ulcerative colitis ☐ Yes ☐ No
14. ☐ Crohn’s disease ☐ Yes ☐ No
15. ☐ First degree relative with colorectal cancer or adenomatous polyps ☐ Yes ☐ No

*STOP IF ANYTHING CHECKED YES IN SECTION 2*

Section 3: Colorectal Cancer Screening

**COLONOSCOPY**

16. Colonoscopy exam completed:
   ☐ No ➔ Go to #17
   ☐ Yes ➔ complete this section and then skip to #18

<table>
<thead>
<tr>
<th>Date of colonoscopy (if more than 2, only report the 2 most recent tests)</th>
<th>Source(s) of information (check all that apply)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date <em><strong>/</strong></em>_ (MM/YYYY)</td>
<td>☐ Primary Care Provider Notes ☐ Endoscopy Procedure Notes ☐ Hospital Discharge Notes ☐ Pathology Report Confirmed</td>
<td>☐ Negative ☐ Positive ☐ Unknown</td>
</tr>
<tr>
<td>☐ Unknown</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date <em><strong>/</strong></em>_ (MM/YYYY)</td>
<td>☐ Primary Care Provider Notes ☐ Endoscopy Procedure Notes ☐ Hospital Discharge Notes ☐ Pathology Report Confirmed</td>
<td>☐ Negative ☐ Positive ☐ Unknown</td>
</tr>
<tr>
<td>☐ Unknown</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17. Colonoscopy referral given:
   ☐ No ➔ Go to #18
   ☐ Yes ➔ complete this section and then go to #18

Date ___/____ (MM/YYYY)
Date ___/____
Date ___/____
Date ___/____
Date ___/____
18. Sigmoidoscopy exam completed:

- No ➔ Go to #19
- Yes ➔ complete this section and then skip to #20

<table>
<thead>
<tr>
<th>Date of sigmoidoscopy (if more than 4, only report the 4 most recent tests)</th>
<th>Source(s) of information (check all that apply)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date <em><strong>/</strong></em>_ (MM/YYYY)</td>
<td>□ Primary Care Provider Notes</td>
<td>□ Negative</td>
</tr>
<tr>
<td></td>
<td>□ Endoscopy Procedure Notes</td>
<td>□ Positive</td>
</tr>
<tr>
<td></td>
<td>□ Hospital Discharge Notes</td>
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<td></td>
<td>□ Pathology Report Confirmed</td>
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<tr>
<td>Unknown</td>
<td></td>
<td></td>
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<td>Date <em><strong>/</strong></em>_ (MM/YYYY)</td>
<td>□ Primary Care Provider Notes</td>
<td>□ Negative</td>
</tr>
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<tr>
<td>Unknown</td>
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<td></td>
</tr>
</tbody>
</table>

19. Sigmoidoscopy referral given:

- No ➔ Go to #20
- Yes ➔ complete this section and then go to #20

Date ___/____ (MM/YYYY)
Date ___/____
Date ___/____
Date ___/____
Date ___/____
Date ___/____

* STOP IF QUESTION 16 OR 18 IS YES *
(Stop if patient has had colonoscopy or sigmoidoscopy)
BLOOD STOOL TEST

Blood stool tests include the Fecal Occult Blood Test (FOBT) and Fecal Immunochemical Test (FIT). In the medical record these tests may be listed as:

- Fecal Occult Blood Test (FOBT)
- Fecal Immunochemical Test (FIT)
- Colorectal Screening Hemo (or Hemocult)

20. Blood Stool Test completed:
   - ☐ No → Go to end  
   - ☐ Yes → complete this section and then go to end

<table>
<thead>
<tr>
<th>Date of test results* (if more than 4, only report the 4 most recent tests)</th>
<th>Type of test</th>
<th>Source(s) of information (check all that apply)</th>
<th>Status</th>
</tr>
</thead>
</table>
| Date ___/____ (MM/YYYY) | □ FOBT  
□ FIT  
□ Unknown | □ Primary Care Provider Notes  
□ Lab Report Confirmed | □ Negative  
□ Positive  
□ Unknown |
| Unknown | | | |
| Date ___/____ (MM/YYYY) | □ FOBT  
□ FIT  
□ Unknown | □ Primary Care Provider Notes  
□ Lab Report Confirmed | □ Negative  
□ Positive  
□ Unknown |
| Unknown | | | |
| Date ___/____ (MM/YYYY) | □ FOBT  
□ FIT  
□ Unknown | □ Primary Care Provider Notes  
□ Lab Report Confirmed | □ Negative  
□ Positive  
□ Unknown |
| Unknown | | | |
| Date ___/____ (MM/YYYY) | □ FOBT  
□ FIT  
□ Unknown | □ Primary Care Provider Notes  
□ Lab Report Confirmed | □ Negative  
□ Positive  
□ Unknown |

* Record only the **date that results were provided**. Do **not** record the date the test was given to the patient (dispensed).

Use this space to record any comments or concerns that are relevant to abstraction

☐ Check this box if additional review of the hard copy record is required.

Please make sure that form is accurate and complete.

Thank you!