EMORY PREVENTION RESEARCH CENTER

CPCRN Cancer Prevention and Control Research Network

SOUTHWEST GEORGIA CANCER COALITION Fighting Cancer... Right Here. Right Now.

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

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Section 1: Patient Demographic Characteristics

5. Date of Birth: ___/___/_____ (MM/DD/YYYY)

6. Gender: ☐ **Male** ☐ **Female**

7. Insurance Status: (Check all that apply)
- ☐ **Medicare**
- ☐ **Medicaid (e.g., Peachstate health plan)**
- ☐ **Private insurance**
- ☐ **Sliding fee scale eligible (i.e., Sliding fee "A-D" scale)**

8. Race (Check all that apply)
- ☐ **African American/Black**
- ☐ **Caucasian/White**
- ☐ **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**

Date of colonoscopy (if more than 2, only report the 2 most recent tests)	**Source(s) of information** (check all that apply)	**Status**
Date ___/_____ (MM/YYYY) ☐ Unknown	**☐ Primary Care Provider Notes** **☐ Endoscopy Procedure Notes** **☐ Hospital Discharge Notes** **☐ Pathology Report Confirmed**	**☐ Negative** **☐ Positive** **☐ Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	**☐ Primary Care Provider Notes** **☐ Endoscopy Procedure Notes** **☐ Hospital Discharge Notes** **☐ Pathology Report Confirmed**	**☐ Negative** **☐ Positive** **☐ Unknown**

17. Colonoscopy referral given:

☐ No → Go to #18 **☐ Yes → complete this section and then go to #18**

Date ___/_____ (MM/YYYY)
Date ___/_____
Date ___/_____
Date ___/_____
Date ___/_____

SIGMOIDOSCOPY

18. Sigmoidoscopy exam completed:

☐ **No → Go to #19** ☐ **Yes → complete this section and then skip to #20**

Date of sigmoidoscopy (if more than 4, only report the 4 most recent tests)	**Source(s) of information** (check all that apply)	**Status**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **Primary Care Provider Notes** ☐ **Endoscopy Procedure Notes** ☐ **Hospital Discharge Notes** ☐ **Pathology Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **Primary Care Provider Notes** ☐ **Endoscopy Procedure Notes** ☐ **Hospital Discharge Notes** ☐ **Pathology Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **Primary Care Provider Notes** ☐ **Endoscopy Procedure Notes** ☐ **Hospital Discharge Notes** ☐ **Pathology Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **Primary Care Provider Notes** ☐ **Endoscopy Procedure Notes** ☐ **Hospital Discharge Notes** ☐ **Pathology Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**

19. Sigmoidoscopy referral given:

☐ **No → Go to #20** ☐ **Yes → complete this section and then go to #20**

Date ___/_____ (MM/YYYY)
Date ___/_____
Date ___/_____
Date ___/_____
Date ___/_____

*** STOP IF QUESTION 16 <u>OR</u> 18 IS *<u>YES</u>* ***
(Stop if patient has had colonoscopy <u>or</u> 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**

Date of test results* (if more than 4, only report the 4 most recent tests)	**Type of test**	**Source(s) of information** (check all that apply)	**Status**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **FOBT** ☐ **FIT** ☐ **Unknown**	☐ **Primary Care Provider Notes** ☐ **Lab Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **FOBT** ☐ **FIT** ☐ **Unknown**	☐ **Primary Care Provider Notes** ☐ **Lab Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **FOBT** ☐ **FIT** ☐ **Unknown**	☐ **Primary Care Provider Notes** ☐ **Lab Report Confirmed**	☐ **Negative** ☐ **Positive** ☐ **Unknown**
Date ___/_____ (MM/YYYY) ☐ Unknown	☐ **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!