

Colorectal Cancer (CRC) Post Screening Evaluation Form

Client Name (Last, First):	ID:	Cycle #:
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If patient with cancer was not referred for further work-up or treatment go to 'Summary of Diagnostic Work-up and Treatment of Cancer' section on page two, all others proceed to 'Program Eligibility' section below.

Program Eligibility

Is client eligible for additional work-up, treatment, or case management services by Program?

- Yes, funds available (*Go to Eligible Client Section*)
 No (*Go to Ineligible Client Section*)
 Yes, but funds not available (*Go to Eligible Client Section*)
 Unknown (*Go to Cycle Closure Section*)

Ineligible Client (Complete through Cycle Closure section)

Reason for Ineligibility (*check all that apply*):
 Age Income Health insurance

 Residency Other, specify: _____

Was ineligible client referred elsewhere for diagnosis/treatment? Yes, referred to: _____
 No

Ineligible Client Outcome (*check only one*):

- Client consulted/scheduled appt./saw health care provider (HCP)
 Client plans to see HCP
 Client declined to see HCP Client lost to follow-up

Final disposition of ineligible clients who contacted an HCP (*check only one*):

- Not Cancer (cancer ruled out by diagnostic tests)
 Refused Unknown

Other, specify: _____

Adenoma

If adenoma required surgery, specify treatment status:

- Started treatment Treatment not indicated
 Refused treatment Lost to follow-up
 Moved Other, specify: _____

Cancer, specify type:

If cancer required surgery, specify treatment status:

- Started treatment Treatment not indicated
 Refused treatment Lost to follow-up
 Moved Other, specify: _____

Comments:

Cycle Closure (for Ineligible Clients or Clients with Unknown Eligibility)

Date cycle closed: / /

Cycle Outcome: Cancer detected No cancer detected

 No cancer suspected Abnormal, cancer status unknown

CRC risk based on cycle screening and client and family history:
 Average risk Increased risk

Screening Recall: Fecal test:

(check all that apply)
 FOBT or FIT, in ____ month/years (circle one). Projected date (mm/yyyy): _____
 DCBE, in ____ month/years (circle one). Projected date (mm/yyyy): _____
 Sigmoidoscopy, in ____ month/years (circle one). Projected date (mm/yyyy): _____
 Colonoscopy, in ____ month/years (circle one). Projected date (mm/yyyy): _____
 Other, in ____ month/years (circle one). Projected date (mm/yyyy): _____
 If Other, specify: _____

If no recall, complete Client Discharge Form.

Recall and/or Closure Cycle Comments:

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Client Name (Last, First):	ID:	Cycle #:
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Eligible Client		
Diagnosis/Treatment Payer: <i>(check all that apply)</i>		
<input type="checkbox"/> CRF	<input type="checkbox"/> Medical Assistance	<input type="checkbox"/> Medicare
<input type="checkbox"/> Self	<input type="checkbox"/> Other, State	<input type="checkbox"/> Charity care/uncompensated
<input type="checkbox"/> MCF	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other, specify:
Was eligible client referred for evaluation and/or treatment?		
<input type="checkbox"/> Yes		Referred to: _____
		Date of Referral appointment: _____ / _____ / _____
<input type="checkbox"/> No, explain: _____		
Were additional procedures or surgeries completed?		
<input type="checkbox"/> Yes <i>(Complete a CRC Supplemental Procedure Form)</i>		
<input type="checkbox"/> No		
Final Hierarchical Diagnosis (system generated):		
Status of Diagnosis:		
<input type="checkbox"/> Complete	<input type="checkbox"/> Died	<input type="checkbox"/> Chose other provider
<input type="checkbox"/> Refused	<input type="checkbox"/> Lost to follow-up	<input type="checkbox"/> Treatment only
<input type="checkbox"/> Moved	<input type="checkbox"/> Pending final diagnosis	<input type="checkbox"/> Unknown
Date of Diagnosis: / /		

Summary of Diagnostic Work-up and Treatment of Cancer		
Was/is cancer treatment recommended?		
<input type="checkbox"/> Yes, completed during screening/diagnostic work-up		<input type="checkbox"/> Yes, further treatment needed
<input type="checkbox"/> No		
Treatment Type/Comments: <i>(Include polypectomy, surgery, radiation, chemo, etc.)</i>		
Date first treatment began: / /		
Treatment Status:		
<input type="checkbox"/> Started/completed	<input type="checkbox"/> Deceased	<input type="checkbox"/> Lost to follow-up
<input type="checkbox"/> Refused	<input type="checkbox"/> Unknown	<input type="checkbox"/> Moved
<input type="checkbox"/> Other, specify: _____		
Tumor	Nodes	Metastases
<input type="checkbox"/> T1 <input type="checkbox"/> T2	<input type="checkbox"/> Positive	<input type="checkbox"/> Positive
<input type="checkbox"/> T3 <input type="checkbox"/> T4	<input type="checkbox"/> Negative	<input type="checkbox"/> Negative
<input type="checkbox"/> Tis <input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown
		Stage
		<input type="checkbox"/> 0 <input type="checkbox"/> I
		<input type="checkbox"/> II <input type="checkbox"/> III
		<input type="checkbox"/> IV <input type="checkbox"/> Unknown/Not Determined
Hospitalized:		
<input type="checkbox"/> No		<input type="checkbox"/> Unknown
<input type="checkbox"/> Yes, hospital:		Date of first admission: / /
Hospice:		
<input type="checkbox"/> No		<input type="checkbox"/> Unknown
<input type="checkbox"/> Yes, facility:		Date of first service: / /

Cycle Closure (for Eligible Clients)		
Date Cycle Closed: / /		
Cycle Outcome:		
<input type="checkbox"/> Cancer detected		<input type="checkbox"/> No cancer detected
<input type="checkbox"/> Abnormal, cancer status unknown		<input type="checkbox"/> No screening done, cancer dx and tx only
CRC risk based on cycle screening and client and family history: <input type="checkbox"/> Average risk <input type="checkbox"/> Increased risk		
Screening Recall:		
<input type="checkbox"/> Fecal test:		
<input type="checkbox"/> FOBT or <input type="checkbox"/> FIT, in ____ month/years (circle one).		Projected date (mm/yyyy): _____
<input type="checkbox"/> DCBE, in ____ month/years (circle one).		Projected date (mm/yyyy): _____
<input type="checkbox"/> Sigmoidoscopy, in ____ month/years (circle one).		Projected date (mm/yyyy): _____
<input type="checkbox"/> Colonoscopy, in ____ month/years (circle one).		Projected date (mm/yyyy): _____
<input type="checkbox"/> Other, in ____ month/years (circle one).		Projected date (mm/yyyy): _____
If Other, specify: _____		
If no recall, complete Client Discharge Form.		
Recall and/or Closure Comments:		