Maryland Department of Health and Mental Hygiene, Center for Cancer Prevention and Control
Guidance for Cancer Client Database (CDB) Form Completion: Colorectal Cancer Screening

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
1	Program Use Only	Jurisdiction	Local Program/Jurisdiction name. This field is automatically filled (auto fill) in the CDB with your jurisdiction/program name because you can only enter or see data for your own program/county.	System generated
		Interviewer	Enter the person's name who interviewed the client to obtain the information for this form, or enter the person's name who reviewed the information provided by the client if the client completed the form him/herself. We highly recommended that you interview the client to obtain this information because clients may not fully understand the questions regarding CRC history and symptoms.	No
		Outreach Worker	If an outreach worker was involved in the recruitment of the client, you may enter the name or initials here.	No
		Educator	If a health educator is working with this client for recruitment or other educational purposes, you may enter the name or initials here.	No
		Case Manager	If a case manager or nurse is assigned to this client, you may enter the name or initials here.	No
		Interview Date	- "Interview Date" is the "Cycle Start Date" and must be entered. This is the earliest date in the cycle. - Enter the date that the information on this page was collected. - If your program wants to retrospectively enter a procedure performed prior to the cycle start date, you must change the cycle start date and the module enrollment date so they precede the earliest procedure date. Go to the Client Information Page to change module enrollment date. The system will not allow you to enter any procedures in a cycle with a date that precedes these dates.	Yes
		CDB ID	System generated CDB Client ID number. This is a unique identifier.	System Generated
		Local ID	If the client has a local ID and you have entered it on the Core form it will appear here in the CDB.	System Generated
		Cycle Number	System generated Cycle Number.	System Generated
		Date of Entry into CDB	This will not appear as a data entry field on the CDB computer entry screens. The CDB will generate a date based on the actual date of entry; however, filling out this field on the hard copy form when you enter the data may help ensure that the data does get entered.	System Generated
		Sponsor	The Program funding the screening, diagnosis, and/or treatment.	Auto fill
	Patient Information	Last Name	Will auto fill from data in the Core.	System Generated
		First Name	Will auto fill from data in the Core.	System Generated
		Date of Birth	Will auto fill from data in the Core.	System Generated
		Age at Screening	- Will auto fill if you click on the field. The age is calculated from the Date of Birth and the Interview Date. - If you change the interview date at a later point you may get an error message saying this age does not match with the date of birth. If this happens you should delete the age in this field and click on it again it will recalculate the correct age based on the corrected interview date. - If the CDB does not compute an age, you should check your data entry on the date of birth in the Core form to make sure it is entered correctly with the appropriate slash marks.	System Generated
		SSN (last 4 digits)	Will auto fill from data in the Core.	System Generated

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1	History	Client History of colorectal cancer?	Check "**Yes**" If the client has ever been diagnosed with CRC, carcinoid, or lymphoma in the colon and indicate the date of diagnosis. The date is a text field and will accept partial or complete information about the date of diagnosis (e.g., year alone, or month and year). Check "**No**" if the client has never been diagnosed with CRC. (If the client has a history of anal cancer but has never been diagnosed with CRC you should check "No.") Check "**Unknown**" if the client has been told by a Health Care Practitioner that he/she may have CRC but it has never been definitively diagnosed.	Yes
		Client History of colon adenomatous polyps/ adenoma?	Check "**Yes**" if the client has a history of adenoma(s). Client must have had a previous sigmoidoscopy or colonoscopy or colorectal surgery in order to have an adenoma diagnosed. Check "**No**" if no adenomas or if hyperplastic polyps or other type of polyp was found on previous CRC screening/diagnostic procedures. Check "**Unknown**" if the client has had previous procedures, e.g., colonoscopy or sigmoidoscopy, but does not know if any polyps were found; Check "**Polyps, type not known**" if the client knows s/he had polyps but either the client doesn't know the type that were found or there was no pathology on the polyps removed (e.g., ablated polyps, polyps removed but were lost and no pathology is available). If the client has had polyps removed but he/she is not sure what kind they were, check "Polyps, type not known" but then correct to the right answer if you are able to obtain information on the type of polyp(s).	Yes
		Client History of inflammatory bowel disease (IBD)?	Check "**Yes**" if the client had inflammatory bowel disease (IBD), that is, Ulcerative colitis or Crohn's colitis. - Specify the type of IBD if known, "Ulcerative Colitis" or "Crohn's Colitis" or "Both Ulcerative and Crohn's" and enter the date of first diagnosis or onset. If the type of IBD is unknown check "Unknown, not specified for the type." - The date of diagnosis is a text field and you may enter year, month and year or full date. This date is important as the longer a client has had IBD the greater the risk of CRC and therefore the need for more frequent surveillance colonoscopies. (See CRC Minimal Elements for guidance on recall intervals for clients with a history of IBD.) - IBD does NOT include irritable bowel syndrome (IBS) or other types of "colitis" such as "spastic" colitis or just plain "colitis" that is not confirmed Ulcerative colitis or Crohn's colitis. Other "colitis" information can be put in the "Comments on CRC History" field. - The client must have had a previous DCBE, colonoscopy, or sigmoidoscopy to confirm this diagnosis. Duration of IBD is important when assessing risk for CRC and the age for first screening colonoscopy so it is helpful to get this information. Check '**No**" if the client has never been diagnosed with IBD. Check "**Unknown**" if the client is uncertain if she/he has ever been diagnosed with IBD. This would be the appropriate choice for clients who may have had IBD symptoms and may have been told there is a possibility of IBD but have never had a definitive diagnosis or for clients who are not sure what the diagnosis of these symptoms actually was.	Yes
		Client History of:	Check "**Ovarian or Endometrial Ca<50 yr.**" if client reported, on the Core form, page 3, "History of any cancer," a history of ovarian or endometrial (or uterine) cancer diagnosed before the age of 50. Check "**Pelvic Radiatio**n" if the client reported any history of radiation to the pelvis at any age. This includes radiation to any pelvic organ, e.g., seed implants or external beam radiation for prostate cancer, bladder cancer, ovarian cancer, cervical cancer, endometrial cancer or any other region in the pelvis.	Yes

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1	History	Client History of:	Check "**None**" if client was not diagnosed with ovarian or endometrial (or uterine) cancer before the age of 50 and has never received pelvic radiation at any age.	Yes
		Family History of adenoma, polyp type unknown, or CRC in First Degree Relative (parent, sibling, child)?	Check "Yes" only if the CRC or adenoma was diagnosed in a parent, sibling, or child (i.e., first degree relative [FDR]). Check "No" if there were no FDRs with CRC or adenomas. - Grandparents, aunts, and uncles are **NOT FDRs**. You can put notes about these other relatives in the "Comments on CRC History" field but you should only mark this box as "Yes" if it is a FDR with CRC or adenoma. - FDR's diagnosed with CRC should be entered in the left columns along with the age at diagnosis if known. FDRs diagnosed with adenomas should be entered in the right columns with the age at diagnosis. Often people will not know the age of diagnosis for the cancer cases but can tell you the age of death. You can enter that age, but please put a note in the "Comments on CRC History" section indicating that this is the age of death and not necessarily the age at the time of diagnosis. -If the client is uncertain whether the polyps removed in a FDR were adenomatous or not select the "polyp type unknown" option in the drop down box. Check "Unknown" if the client was adopted and/or unable to obtain family history information.	Yes
		Comments on CRC History	- Family or personal history of genetic syndrome that increases a person's risk, for example, familial adenomatous polyposis (FAP); hereditary nonpolyposis colorectal cancer (HNPCC) also known as Lynch syndrome. If the client reports any of these syndromes, it should be noted here.	No
		CRC Risk based on client and family history	- Refer to the CRC-Risk Definitions in the Help menu or the CDB User Guide to determine risk. The client is at increased risk if he/she has a personal history of CRC, adenomatous polyps. polyps type unknown or inflammatory bowel disease (Crohn's or Ulcerative colitis), endometrial or ovarian cancer diagnosed before age 50, pelvic radiation at any age, or if he/she has a first degree relative with a history of CRC, adenoma, or polyp type unknown. - Note that symptoms are not taken into account in the risk assessment process. - Check "Increased Risk" if the client has personal or family risk; otherwise check "Average Risk." - For subsequent cycles, risk will include the findings on prior screening(s). If the client was found to have CRC or adenoma(s) or if family or personal history change, update the risk to "Increased Risk." - If a returning client at Increased Risk has a colonoscopy screening without findings of CRC or adenoma, the client remains at Increased Risk because of prior personal or family history and does not revert to Average Risk. On the other hand, if the client was at Increased Risk because of polyps of Unknown type and you find that they were NOT adenomas, you may correct the risk history and put the client at Average Risk.	Yes

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1	Symptoms	Does client have GI symptoms possibly suggesting colorectal cancer?	This field refers to symptoms that could possibly suggest CRC, as reported by the client or by his/her provider. Ask the client about the symptoms listed on the form. Check "**No**" if the client reports no symptoms suggestive of cancer; (Please note that if symptoms are noted on the pre-screening or physical exam notes from the physician then this field should be corrected to reflect the symptoms noted and a note should be placed in the "Comments on Symptoms" field indicating that these symptoms were not noted on intake but were documented in the provider notes.) - If the only symptoms the client reports are bowel problems not suggestive of cancer, for example chronic constipation for the past 10 years, you should check "No" to symptoms suggestive of cancer but then document this information in the "Comments on Symptoms" field. Check "**Unknown**" if you cannot determine if there are symptoms; Check "**Yes**" and complete the additional fields that specify the symptoms if the client reports any of these symptoms listed. - Symptoms the client may report include lower abdominal pain; bright red blood per rectum (that is, out of the rectum), bloody stools; marked change in bowel habits; unexplained weight loss. Other symptoms may include mass in the abdomen, difficulty having a bowel movement, marked weight loss, etc. Examples of marked change in bowel habits include "penciling" of stools or a significant increase in stool frequency associated with cramping abdominal pain. - If the client indicates bloody stools, please note in the "Comments on Symptoms" field more about the nature of the blood/bleeding. For example, does it occur only with hard stools on the toilet paper, or is it blood in the toilet bowl, black tarry stools, etc.? - Any information you can provide in Comments on Symptoms and Medical History about the symptoms can help you determine the possible causes and can help you to triage the urgency of the need for the colonoscopy. - If the source of the symptom history is the provider, please note this in the "Comments on Symptoms" field. - Some programs do not screen clients who report "symptoms"; therefore, it is important to get enough information about the symptoms to try to determine if this person would be eligible for your program or would need referral to a provider outside of your program. - Reports such as "prior positive FOBT" are not considered "symptoms" but should be noted in the previous screening history.	Yes
		Comments on Symptoms and Medical History	Enter pertinent comments by the client or their provider regarding symptoms and medical history. If symptoms or history are vague, elaborate on the information as reported by the client. The box on the form is small, but the CDB screen will allow 500 characters of text.	No

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1	Previous Screening History	If client was previously tested for CRC outside of this Program, specify the tests and results	- Note here only screening tests done **OUTSIDE** of the program. All screening done in the program will be documented in the CDB so it is not necessary to repeat it here. If no prior screening was done, you can leave this section blank. - The CDB allows for only one entry of each kind of procedure so if you want to document more than one colonoscopy you put the second one in as "other" and under "(specify)," note that it was a colonoscopy. You may want to do that for clients who have had significant findings on the first procedure but have had subsequent procedures outside of the program with negative findings. - The Date field will accept a partial date, e.g., year only, month and year, or the complete date if you have it The Results and Provider fields are text fields so you can write information you have, e.g., "normal" or "negative" or "polyp, type unknown." Acquiring the name of provider or location where it was performed will enable you to request the records if it was done locally within the last 7 years. The past records can help clarify the number, size and type of polyps found on the prior procedures which may have implications for when the next recall should be done following the procedure done in your program. - For cycles 2 and greater, list only screening tests done **OUTSIDE** the program between the prior CRC screening cycle in the program and this cycle.	Yes
2	Other Medical History	Does the client have history of (check all that apply):	This list includes medical problems that might put the client at risk for complications from screening colonoscopy/sigmoidoscopy or surgical procedures. Refer to the specific list of diseases/conditions on the form. Check all that apply. Add other issues/explanations in Nurse's Notes. Use this information to counsel the patient and to alert the endoscopist (the person doing the sigmoidoscopy or colonoscopy) or surgeon of risk factors. If the client has none of the listed items check "None of the following" so it is apparent that you did ask the client these questions.	No
	FOBT/FIT (Fecal Occult Blood Test/Fecal Immuno-chemical Test)	Kit Given	Indicate "Yes" or "No" for every client. If your site does not give out FOBT or FIT kits, it will always be "No" but it should be noted rather than left blank. If "No," you may skip to the Screening Eligibility Section and leave the rest of the FOBT/FIT section blank.	Yes
		Type	Indicate whether the type of kit given was an FOBT or FIT.	Yes
		Date Given	Enter the date the kit was given out. This will help you decide when you want to contact the client to remind him/her to return it or close the case out as "no screening" if it is not returned within a reasonable period of time.	Yes
		Kit Returned	Check "**Yes**" when kit is returned. Check "**No**" if kit is not returned in a reasonable period of time (your program can determine how long you want to wait). If "No," you can skip to the Screening Eligibility Section and leave the rest of the FOBT section blank.	Yes
		Date Kit Returned	This is the date the client returned the kit to you or to the doctor or lab doing your processing.	Yes
		Kit Results:	Check "**Positive**" if it is an FOBT kit and one or more of the windows is positive. If it is a FIT test, document the results per the manufacturer's recommendation as the reporting is currently not standardized and will differ from one manufacturer to another. Check "**Negative**" if none of the windows are positive for an FOBT. If it is a FIT test follow the guidelines provided by the manufacturer for a negative finding. Check "**Other, specify**" if you do not have enough information to verify whether or not the test was positive, e.g., insufficient sample.	Yes

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2	FOBT/FIT (Fecal Occult Blood Test/Fecal Immuno-chemical Test)	Date Results Received by Program	Enter the date that your program got the FOBT/FIT results, for example, the date your office developed the kit or the date you received the report from the lab.	Yes
		Client Notified of Screening Results?	- Check "**Yes**" in the CDB if you are sure that the client was notified of his/her results; - For negative FOBT/FIT, this means that you spoke to the client (by telephone or in person) or sent a letter informing the client of the results; - For positive FOBT/FIT, this means that the client spoke to you or received a certified letter with signature of the client that he/she received the letter. - Check "**No**" in the CDB if the client was not notified by the above means. - We require and assume that the program attempts to reach each client about the results. "Client Notified" does not mean that "an attempt was made to notify the client." If you attempted notification but were unsuccessful, then check "No" and document the ways you attempted to notify the client in the "Notification Comments" field.	Yes
		Date Program Notified Client	Enter the date that someone in your program first notified the client. For example, the date of the phone conversation would be the date entered, even if you later sent a letter. The Date Program Notified Client cannot precede the date you received the results.	Yes
		Type of Notification	Indicate all the way(s) in which you actually reached the client to notify him/her of results. You may have tried numerous ways and these can be documented in the "Notification Comments" section or Nurse's Notes, but for this section, enter how the client was actually reached for notification.	No
	Screening/ Services Eligibility (Beyond FOBT)	Eligible for Screening Endoscopy by Program	This asks for eligibility for colonoscopy or sigmoidoscopy or other expensive screening (DCBE, etc.), diagnosis and/or treatment in the Program (beyond FOBT or FIT). Check "**Yes**" if the client meets age, residence, income, and health insurance requirements to qualify for colonoscopy or sigmoidoscopy, or other expensive screening, diagnosis, or treatment in the CRF Program beyond and FOBT or FIT. Check "**Yes**" for eligible clients coming into the Program for Diagnosis and/or Treatment Only. Check "**No**" if not eligible and indicate the reason why the client was not eligible. Proceed to Cycle Closure if the FOBT or FIT was negative or not returned and there were no risk factors or symptoms indicating the need for a colonoscopy. If the FOBT or FIT was positive or there were risk factors or symptoms indicating the need for a colonoscopy, proceed to page 1 of the CRC post screening form to document the case management for this ineligible client. Check "**Not Applicable/Unknown**" and proceed to Cycle Closure if: - Program does not ask client for eligibility information (e.g., average risk client with negative FOBT for whom Program will not pay for colonoscopy unless the client calls back and goes through Program eligibility process.) - Client does not provide the Program with the information needed to determine eligibility.	Yes

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2	Screening/ Services Eligibility (Beyond FOBT)	Screening/ Diagnosis Payer	Indicate the source(s) of payment for the screening and diagnosis procedures. In most cases, for eligible clients, this will be CRF (Cigarette Restitution Fund). If the client has insurance that will cover part of the bill and CRF is just paying the co-pay or the deductible, then mark the applicable insurer(s), such as Medicare, and also check CRF. Please note that the if the sponsor specified for this cycle is other than CRF than the specified sponsor should be the primary payer for procedures in this cycle. If the primary payer is not the specified sponsor you will need to correct the sponsor field. This is done on the Client Information page.	Yes
	Screening Recommend ed	Pre-screening; Physical Exam; Sigmoidoscopy; Colonoscopy; Imaging	Check all exams/procedures that are recommended during this cycle. Checking these boxes opens a procedure for each so you can then enter information including date the procedure or exam is scheduled, the date completed, and results, or indicate why it was not done. It is important to enter all procedures recommended (initially and during the course of screening) so it is clear what the plan was for that cycle and why the procedures were not completed if any of them were not done as recommended. - If initially a colonoscopy was checked on this page but was found to be inadequate and an Imaging test is recommended to complete the screening, check Imaging on page 2 and then specify the type of Imaging recommended (DCBE, SCBE or Virtual Colonoscopy) and a procedure will be created which you can access via Additional Procedures in order to complete the data entry for this procedure. - There is a difference between a pre-screening exam and a physical exam. If the exam is done by the surgeon or gastroenterologist who is going to do the colonoscopy or sigmoidoscopy, then it is most likely a pre-screening exam. If your Program pays for both a full physical and a pre-screening exam you can enter both. Check off both exams on page 2. Only one of the two can be entered on the top of page 3; either one you want to enter there is fine. The other one (pre-screening or full physical exam) will appear in the Additional Procedures list. When you click on this choice from the drop down menu at the top right hand side of the page, you can then click on "edit" for that procedure and enter the data. Note: 1) If a prostate specific antigen test (PSA) is performed as part of the physical exam, do not enter it in the CDB as a screening procedure on the prostate module. Note the findings of the exam in the findings field for the physical exam in the CRC module. 2) If a DRE is performed as part of the physical exam, enter the DRE in the findings field for the PE in the CRC screening cycle. Do not enter it as a screening procedure in the Prostate Module. 3) If PSA is elevated or if DRE is abnormal, the prostate module should be opened but no screening procedures should be entered. Only enter diagnostic procedures such as a repeat PSA or urology consult. The first page of the screening form should be completed and elgibility or screening checked as "Yes" as well as "Refer for further evaluation to r/o cancer" on page 3. This will open the post screening form.	Yes
		Date Scheduled	Enter the date the exam or procedure is scheduled.	No
		Date Re-scheduled	Enter the date the exam or procedure is rescheduled if applicable. If the appointment has to be changed for any reason you can enter the new date here.	No

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2	Screening Recommended	Provider	This refers to the provider who is scheduled to do the procedure. If you enter the provider name, it will auto fill on the next page. - Choose from the drop down list of provider names. If it is a provider who is not on the drop down list, you cannot link to the provider page to add the new provider from this section. You might want to enter it on the procedure results screen on page 3 instead, or go to Add Provider from the main menu and add the name so it will appear in the drop down list. - All providers for screening procedures should be entered by the individual provider's name rather than by the practice name so it is possible to determine which provider in the practice performed the procedure.	No
		Not Performed in CRF Program: (select reason)	- If the recommended exam or procedure was not performed you can specify here why it was not performed. This will cancel the procedure in Additional Procedures and the reason it was not performed will appear on the line list report so you can see at a glance how many clients have refused exams or been lost to follow-up or what ever other reasons may have been noted. - If you do not indicate why it was not performed and there are no results entered for the exam, it will continue to appear as "pending" until you indicate why it was not done, or delete the procedure altogether from the Additional Procedures drop down list. - If you cancel a procedure by indicating why it was not performed and then the procedure is in fact completed you need to uncheck the reason not done and then navigate to page 3 in order to allow data entry for the procedure.	No
		No screening recommended	Check this box if no procedures or exams beyond the FOBT or FIT test were recommended though the client was eligible for additional screening. You can only check this box if you have not checked any recommended procedures above. This is the box you would chose if, after communication with the provider, the provider determines that it is not necessary to see the client for a pre-screening exam or a physical and that no screening is needed at this time.	No
		See own doctor, specify details:	Check this box if the provider refers the client back to his/her own doctor rather than recommending any exams or procedures for the client in this cycle.	No
		Other screening recommended, specify details:	Check this box if the provider does not recommend a pre-screening or a physical exam in the program, or any of the standard CRC screening exams beyond an FOBT or FIT, but does recommend other tests such as a CEA level or a CT scan. This is an option you might check for a client who is receiving only diagnostic and treatment procedures in this cycle.	No
3	Results from Exams	Type of exam (Physical or Pre-Screening Exam)	If only one of the two (pre-screening or PE) was selected on page 2, then the type of exam will be auto filled here. If both exams were recommended you will need to indicate which one you are recording on this page. The second one will appear in Additional Procedures.	Yes
		Date of Exam	Enter the date the physical exam or pre-screening visit occurred.	Yes
		Provider	Enter the name of the provider who performed the exam. This field will auto fill the provider's name if you entered it on page 2. If the exam was performed by a different provider than the one with whom the client was originally scheduled, you can change the provider in this field and it will automatically change on page 2 as well.	No
		Date Results Received by Program:	Enter the date the Program received the results of this exam.	Yes

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3	Results from Exams	Significant Findings	- This is a required field so you need to enter something here or it will be flagged as missing data when you close the cycle or run the Required Fields Validation. - Enter a note such as "None," "Within normal limits (or WNL)," or "Cleared for colonoscopy" if there were no significant findings, findings were within normal limits, or if no additional testing is needed before the procedure can be done. If there are significant findings from the exam such as a Hemoccult positive DRE or new information about the health history or family history or presenting symptoms not noted previously, you should document it here. - If the doctor does not clear the client for the recommended procedure due to health problems that cannot be resolved in the Program (e.g., not a good surgical candidate due to cardiac problems), then mark the reason the procedure will not be done on page 2 as "No longer recommended"; document here in "Significant Findings" why the client was not able to undergo the procedure.	Yes
		Client Notified of Exam Results	Check "Yes" if either the provider who did the exam or the Program notified the client of the results. For example, at the end of the exam the doctor may tell the client, "You are fine to have your colonoscopy"; in most cases this will be the case. Check "No" if there were test results pending from this exam that required notification at a later date, e.g., cardiac testing or blood work was done, and the client was lost to follow-up before the results could be given to the client.	Yes
		Date Client Notified	Enter the date when the client was notified of the results by the Program or the provider, whichever is earlier. In most cases, this will be the date of the exam when the provider informed the client of the results.	Yes
		Notified by whom	Person who notified client of exam results--usually for the pre-screening or physical exam it is the provider.	No
		Type of notification	Most often In-person, verbally; sometimes later by phone or mail if it involves test results not available at the time of the exam, e.g., blood work.	No
		Notification Comments	May record any comments regarding notification; for example, if there were any difficulties in reaching the client to notify him/her re: results, you can note it here.	No
	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Procedure	- You must select the procedure as a Recommended Procedure on page 2 in order to record the results on page 3. - If you have selected only one procedure on page 2 (Sigmoidoscopy, Colonoscopy or Imaging), this field will be "auto filled" with the name of that procedure. - If you have selected more than one procedure on page 2, you will need to choose which one you are going to enter on page 3 from the drop down. After you have selected the procedure to enter on page 3, the second procedure will automatically appear in the Additional Procedure list and will no longer be a drop down option on page 3; you will need to go to Additional Procedures to add information regarding the second procedure.	Yes
		Date Performed	Date the procedure was actually performed. This will NOT auto fill from Date Scheduled on page 2. The date performed must be entered in order for the procedure to get counted in the reports.	Yes
		Provider	Enter the name of the provider who performed the exam . This field will auto fill the provider's name if you entered it on page 2. If the exam was performed by a different provider than the one with whom the client was originally scheduled, you can change the provider in this field and it will automatically change on page 2 as well.	Yes
		Biopsy Done	If any biopsy specimens were obtained and sent to the lab, then you should check "Yes." You should have a pathology report detailing the findings unless the endoscopist specifies that the specimen collected was lost in retrieval and was, therefore, not sent to the lab.	Yes

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3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Was bowel prep adequate?	This field indicates whether the bowel preparation was adequate for a Sigmoidoscopy, Colonoscopy, or Imaging. Adequacy of the bowel preparation will be determined by the clinician performing the test. - Check "**Yes**" if the procedure report explicitly states that the bowel preparation was "adequate," "good," "excellent," "fair" or if the provider indicates that despite a less than adequate prep, an adequate view was obtained after irrigation of the bowel. (See below regarding coding for bowel prep described as "fair" with a short recall.) - Check "**No**" if the procedure report indicates "poor prep," "inadequate prep," "small polyps may have been missed" **OR** if the provider states that the prep was "fair" but recommends a recall interval that is shorter than would be recommended per the Minimal Elements for the given risks and findings because of the prep. - Check "**Unknown**" If the prep adequacy is not stated in the report.	Yes
		Was cecum reached, if colonoscopy?	Check "Yes" if the endoscopist documents having gotten to the cecum or otherwise describes having gotten a good look at the cecum to rule out lesions. Check "No" if the endoscopist describes the procedure as NOT having gotten a good look at the cecum to rule out lesions. Check "Unknown" if it is not documented in the report. If the client had prior surgery and has no cecum (e.g., prior bowel resection, hemicolectomy) but the colonoscope reached the end of the remaining colon, check "Yes."	Yes
		Adequate Exam	For Colonoscopy, "Adequate Exam" is based on whether the bowel prep was adequate and whether the cecum was reached. This field is **auto filled** for Colonoscopy based on the responses to "Was bowel prep adequate?" and "Was cecum reached, if colonoscopy?" For Sigmoidoscopy and Imaging, read the reports and enter "Yes," "No," or leave blank based on the adequacy of the bowel prep and any other information you find in the procedure reports. For Colonoscopy: - Will auto fill as "**Yes**" if "bowel prep adequate?" and "was cecum reached?" are both checked "Yes." - Will auto fill as "**No**" if either "bowel prep adequate?" is "No" OR if "was cecum reached?" is "No." - Will auto fill as **blank** if either "bowel prep adequate?" or "was cecum reached?" is checked "Unknown" or left blank. **Note**: For **recall** following an **inadequate** endoscopy exam, if the doctor has not specified a recommendation for repeating the exam or follow-up with Imaging or an FOBT or FIT to complete the screening, then you should contact the doctor to verify that the exam was inadequate and discuss plans for completing the screening in a reasonable time frame. If Adequate Exam = "No," please specify in the "Comments on Findings" why it was inadequate, e.g., prep was poor, or why the procedure was terminated before reaching the cecum and how much of the colon was actually viewed.	System generated for colonoscopy
		Date Results Received by Program	Enter the date that the Program has received all the information needed to notify the client. This includes the procedure and the pathology report (if there is a pathology report) and the provider's recommended recall interval. - Please note that this is a benchmark interval. The goal is to not have this date exceed 28 days from the date of the procedure. - Please note that the date the client was notified cannot precede this date.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Findings	Please account for all the findings that the endoscopist, radiologist, and/or pathologist identifies on the endoscopy or imaging procedure. For polyps: please account for the total number of polyps found by the endoscopist in one or more of the options given on the form as instructed below.	Yes
		Findings: Confirmed Cancer	Confirmed Cancer: Check this box if cancer was confirmed as a result of *this* procedure. Do not include findings on subsequent procedures or surgery. - Confirmed Cancer' should **NOT** be checked if the pathology report shows intramucosal adenocarcinoma or adenocarcinoma in-situ of the colon. Since these lesions are not invasive, they are considered by GI pathologists to behave in the same way as adenomas with high grade dysplasia. There may be situations where the tumor is large, the pathology report shows intramucosal adenocarcinoma or adenocarcinoma in-situ or adenoma with high grade dysplasia, but the endoscopist believes the tumor is actually cancer. In these cases, check 'Suspected Cancer.' Diagnoses for which 'Confirmed Cancer' should be checked include invasive adenocarcinoma, lymphoma, carcinoid tumor, or squamous cell carcinoma of the colon or rectum and squamous cell carcinoma or adenocarcinoma of the anus. - If cancer is suspected at this point but not diagnosed until a later procedure, then check "Presumed/Suspect Cancer" (below) and enter the cancer finding in the procedure in which the specimen was collected that confirmed the cancer (often a surgical procedure.)	Yes
		Type	If the finding is a confirmed cancer, specify the type in this field. The most common type of colorectal cancer is adenocarcinoma. Other, less common, types of colorectal cancer include; lymphoma, carcinoid tumor, or squamous cell carcinoma.	Yes
		Location	Enter the location in the colon that the cancer was found, e.g., rectum, mid-sigmoid, cecum, anus, etc.	Yes
		Findings: Presumed/ Suspect Cancer	Presumed/Suspect Cancer: Check this box when a lesion is identified that is suspicious for cancer but requires further diagnostic work-up (either a repeat biopsy or surgery will determine the final diagnosis) to confirm this diagnosis. Examples include: lesions too large or too inaccessible to remove entirely and the biopsy is insufficient to confirm invasion; suspicious lesions that are not biopsied; specimens with biopsies submitted that were too small to confirm the diagnosis; lesions that look like cancer on colonoscopy (per the endoscopist) but the pathology only says adenoma.	Yes
		Findings: Adenoma	Check this box if the **pathology report** says **"adenoma," "adenomatous polyp," "tubular adenoma," tubulovillous adenoma," "villous adenoma," "serrated adenoma," "traditional serrated adenomas," "sessile serrated adenomas," or "sessile serrated polyp."** - If the pathologist calls the lesion a "serrated polyp," please check with him/her to clarify whether the pathologist considers the lesion an adenoma or a hyperplastic polyp. - As noted above, if the pathology specifies **intra**mucosal adenocarcinoma or carcinoma-in-situ, the finding should be entered as an adenoma with high grade dysplasia rather than as a cancer. You should not check "Presumed/Suspect cancer" for these adenomas unless the provider or the pathologist specifies a concern for cancer, in which case you should enter the polyp as an adenoma and also check "Presumed/suspect cancer." - If an adenoma has developed into an invasive adenocarcinoma it should be entered only as a "Confirmed cancer," not as an adenoma. - If the **procedure** report says “adenoma-like polyp” or “adenoma,” but this is not confirmed by biopsy, do not enter as an adenoma. The polyp should be entered as per the findings of the pathology report. If no biopsy was done of a polyp or if the results indicated something other than an adenoma or a hyperplastic polyp, it should be entered as an "other polyp" (see directions for data entry for "other polyps" below). - If a polyp is noted to have both adenomatous and hyperplastic features or identified as a mixed adenomatous and hyperplastic polyp, enter it as an adenoma and **not** as a hyperplastic polyp.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Adenoma: Number	Enter the number of adenomas/adenomatous polyps found based on the number of polyps described in the procedure report that were biopsied in the specified location(s), that were found to be adenomas. - For example, if there was one polyp removed and it was received in pathology as 3 fragments which were found to be adenomas it would still be just one adenoma if described as only one polyp in the procedure report. Alternatively, if there were two polyps described in the sigmoid colon and the vial submitted to pathology that contained these polyps had two or more fragments in it, it should be entered as two adenomas based on the procedure report description of the two polyps in that region. - If there was more than one polyp removed, read the colonoscopy report and the pathology report carefully to match up and figure out how many polyps were identified as adenomas (and, for the size, below, which one was the largest adenoma). Sometimes one polyp is removed in pieces (sometimes stated as “piecemeal removal”) and "fragments" are received and reported by pathology; that is still one polyp. - If several polyps were submitted to pathology in one vial and the pathology report says, for example, only "tubular adenoma," you have no real way of knowing from the pathology report whether all the polyps submitted in the vial were tubular adenomas or if there was a tubular adenoma identified among the fragments representing only one adenoma. If the specimens are submitted in one vial and the description of the specimens submitted is sufficient to determine that there were a number of separate polyps in the vial and not just fragments of one, you can enter it as more than one adenoma. If you are unsure (that is, the path report just says "fragments"), you can enter it as 1 known adenoma and the rest as "other polyps" (see Other polyps below). - If the provider gives a vague description of the number of polyps, e.g., "multiple polyps" rather than specifying an exact number, on the colonoscopy report, you may need to leave this field blank and just enter the text of the procedure report and what the pathologist found in the Comments on Findings, below.	Yes
		Adenoma: Size of largest adenoma (in mm*)	Adenoma (Size)**:** Enter the size of the largest adenoma **in millimeters.** The conversion between centimeters and millimeters is: cm X 10 = mm. For example, 0.5 cm X 10 is 5 mm; 1.0 cm equals 10 mm; 3 cm = 30 mm. There is a conversion table in CDB Help. - The size of the largest adenoma should come from the *colonoscopy report* whenever possible. The most important distinction for risk determination and recall recommendation is whether any polyp was 10 mm or larger (that is, >= 1 cm). - If there is no size in mm specified in the colonoscopy report and the polyp was removed intact and sent to pathology intact, you may use the size from the pathology report but note in the "Comments of Findings" section that this is where the size came from. Using the pathology report for size is generally only applicable when the entire polyp is submitted to pathology in one piece, and described by the pathologist as such. - If a polyp was removed in pieces ("piecemeal"), the measured size on the pathology report should **not** be used as the size. In these cases, you should just leave the mm size field blank and code the "Large adenoma" field as per the guidance available below, in the CDB by clicking on the question mark next to the Large field, or per the guidance in CDB Help.	Yes
		Large adenoma? (Y/N/U)	This field will auto code if you enter an actual size for the largest adenoma. If you enter a size 10 mm or greater if will code as "Yes." If you enter a size less than 10 mm it will code as "No." If the size was not documented in the procedure report and the polyp was not removed and received in pathology intact, allowing you to use the size from the pathology report, then you should code this field using the drop down box options per the guidance which is available in the CDB by clicking on the question mark next to this field or refer to the guidance in CDB Help.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Adenoma Pathology: Histology	**Adenoma Histology of Most Advanced Lesion**: The histology must come from the pathology report. Look at the histology of all the adenomas from the pagholoy report and decide which is the "most advanced" lesion. - Adenomas with any villous histology are more "advanced" (or more likely to progress to cancer) than tubular adenomas and therefore require shorter recall intervals (see CRC Minimal Elements, Attachment 1). "Tubular" is the least advanced histology, "Tubulovillous" is the next most advanced, and "*Villous" is the most advanced histology* of the three types. - Leave blank if none of these terms are used on the pathology report. - If both a tubular and a villous adenoma were identified, mark "villous" to indicate the more advanced of the two. **Were any of the adenomas called high-grade dysplasia on pathology, (high-grade dysplasia, severe dysplasia, carcinoma-in-situ, intramucosal carcinoma)?** If any of the lesions were described on the pathology report as having "high-grade dysplasia," including other terms such as "severe dysplasia," "carcinoma-in-situ," or "intramucosal carcinoma," check "Yes," if not check "No." **Were any of the adenomas described as "serrated?**" If any of the lesions were noted on the pathology report to be "serrated adenomas" or "traditional serrated adenomas" or "sessile serrated adenomas" or "sessile serrated polyps," check "Yes"; otherwise check "No."	Yes
		Findings: Hyperplastic Polyp(s)	Check the Hyperplastic Polyp(s) box if one or more polyps found are identified in the pathology report as hyperplastic. Note the number of hyperplastic polyps found in the following field.	Yes
		Hyperplastic Polyp(s) Number	**Hyperplastic polyp (Number):** After reviewing the procedure and pathology reports, state the number of polyps identified in the pathology report as hyperplastic polyps. - If a single polyp is noted to have **both** adenomatous and hyperplastic features, enter it as an adenoma and do not count again here as a separate hyperplastic polyp. - The database does not allow you to give the size of the hyperplastic polyps in this section; however, if there are any that are 1 cm or greater, please make a note of it in "Comments on Findings" and indicate whether or not it was removed entirely. Polyps this large could merit an earlier recall or sometimes an additional procedure to ensure the polyp is removed entirely and adequately examined.	Yes
		Suspected Hyperplastic Polyposis	Check the Suspected Hyperplastic Polyposis box if the findings are suspicious for **"hyperplastic polyposis" now called "serrated polyposis."** The definition of serrated polyposis syndrome (formerly called hyperplastic polyposis) is: (1) at least five histologically diagnosed hyperplastic and/or serrated polyps proximal to the sigmoid colon of which 2 are greater than 1 cm in diameter; (2) any number of serrated and/or hyperplastic polyps occurring proximal to the sigmoid colon in an individual who has a first-degree relative with serrated (or hyperplastic) polyposis; or (3) greater than 20 serrated and/or hyperplastic polyps of any size distributed throughout the colon.	Yes
		Findings: Other polyp/polyp type not otherwise specified	Check this field if there are any polyps that you do not account for above as adenomas or as hyperplastic polyps. You should specify why they were "other" in the 'Type/Reason' field in this section below. (See below for why polyps may be counted as "other.")	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Other Polyp Number	**Other Polyp (Number):** The colonoscopy report should specify how many polyps were seen during the procedure. This field captures the number of 'other' polyps (not adenoma or hyperplastic). Do not get the number of polyps from the pathology report *or the number of fragments* because one polyp can be submitted in several fragments.	Yes
		Other Polyp Size	**Other Polyp (Size of largest polyp in mm):** As noted above for determining the size of the largest adenoma, you should use the size specified in the procedure report rather than the size of fragments received in pathology. If no size was specified in the procedure report for the other polyp(s), leave this field blank.	Yes
		Other Polyp Type/reason 'other'	**Other Polyp (Type of polyp/reason 'other'):** Examples of other types of "other polyps" include hamartomatous polyps, juvenile polyps, inflammatory polyps. Other reasons a polyp may be an “Other polyp" can be: - the polyp was not submitted to pathology because it was lost in retrieval, abated without biopsy, or was seen but not removed or biopsied at all (e.g., on sigmoidoscopy without biopsy); - there were too many polyps seen to remove them all; - a vial submitted to pathology that was thought to contain the polyp or fragment of the polyp but the pathologist found no tissue or insufficient tissue for analysis when the contents of the vial was examined. - the polyp was submitted but it was put in a container along with several other specimens and it is impossible for you to tell based on the pathology report how many adenomas or hyperplastic polyps there were in the container. If, for example, all you know is that at least one of several was an adenoma (e.g., the report says "tubular adenoma"), you should note one under Adenoma and put the rest under "other" and just write (all submitted in one vial); and - the lesion identified in the colonoscopy report as a polyp was submitted to pathology but per the pathology findings, was not actually a polyp, e.g., "benign colonic mucosa," or a "lymphoid aggregate."	Yes
		Polyp with unknown pathology	**Polyp with unknown pathology:** Check this box if there are any polyps noted in the colonoscopy report for which there are no pathology findings, e.g., polyps that were ablated without biopsy or not removed or biopsied or were removed but lost to retrieval.	Yes
		Findings: Inflammatory Bowel Disease (IBD)	If IBD is noted as a finding on the colonoscopy report and is confirmed or still suspected by the doctor after review of the pathology report, then IBD should be checked and the type specified. It is best to try to get this diagnosis from the colonoscopist after he/she has had a chance to review the pathology findings.It is also important to document in the Comments on Findings section the extent of inflammation noted and the number and location of biopsies done. You can choose one of the four options: 1) Ulcerative colitis (UC): Check UC if the client is diagnosed by the endocscopist as having ulcerative colitis. This is a very specific finding and must be diagnosed and stated in the pathology report and/or in the doctor's notes or confirmed by the doctor, after reviewing the pathology findings, diagnoses UC. There may be "ulcers" noted during the exam, or "colitis," but this does not mean the diagnosis is UC unless specifically stated as such. 2) Crohn's colitis: This is similar to ulcerative colitis; see 1) above. 3) UC & Crohn's colitis: Check if both conditions apply as described in 1) and 2) above. 4) IBD type unknown: Check this if the path report or the doctor's notes, after path review, indicates that there is evidence of Inflammatory Bowel Disease but the type is not specified.	Yes
		Findings: Diverticuli	Check this finding if there is any mention of one diverticulum, several diverticuli, extensive diverticular disease (sometimes called “tics”) identified during the procedure.	Yes
		Findings: Hemorrhoids	Check this finding if there is any mention of hemorrhoids, internal or external. This is the most common cause of rectal bleeding so the notation is important as it may help explain bleeding symptoms noted on intake.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Findings: Other, specify	Check here if there are findings not covered in any of the finding categories above and specify what the finding is. This would include things like melanosis coli, area of inflammation, ulcers not associated with Ulcerative colitis or Crohn's colitis, lipoma, schwannoma, lymphoid nodule that was not identified initially as polyps, or any other lesion/finding not noted above.	Yes
		Findings: Normal, none of the above findings	- If the exam was inadequate but there were no findings noted in the part of the colon that could be seen, you should check "normal" here and note the exam was "inadequate" above; also indicate in the "Comments on Findings" how far the scope was advanced, if it was advanced to the cecum, and why it was inadequate, e.g., poor prep. This will result in a procedure hierarchical diagnosis of "normal, inadequate."	Yes
		Hierarchical Procedure Result	- This field is "system derived" (auto filled) as a hierarchy of the most advanced finding on this procedure (e.g., cancer > high grade adenoma > adenoma > hyperplastic polyp > other findings, etc.). The Hierarchical Procedure Result can be viewed on the CDB screens after findings are entered. - Because it is system derived, review of this field is a good way to confirm that the findings have been entered correctly. That is if you know there were adenomas found and you documented this in the pathology report field but failed to check adenoma in the findings, the hierarchical procedure result will not reflect the adenoma finding and you will know you need to go back to complete the data entry. See the CDB Help menu document for definitions of the results for each procedure (colonoscopy, sigmoidoscopy, and imaging) as generated by the system. "Hierarchical Diagnosis for Col/Sig/Imaging Results at the Procedure Level."	System Derived
		Comments on Findings:	Use this field to document descriptive information from the procedure report re: any polyps or other significant findings noted. If the exam is inadequate the reason why it was inadequate should be documented here, e.g. prep description if it was inadequate or how far the scope was advanced if it was not advanced to the cecum. From the procedure report, for each lesion noted, please enter: - where in the colon the lesion was found, - how many lesions were found in each location, - if it was a polyp, any descriptive information such as "diminutive," "small," "large," "sessile," or "pedunculated," - the method of removal (e.g., snare, hot biopsy, cold biopsy) and if it was removed completely, if noted, - and the actual size of the polyp if it was specified. If it was **not** specified it is helpful to note that so it is clear why the size of the largest adenoma is blank.	Yes
		Pathology Report:	From the pathology report please enter the following: - a description of each vial submitted. Specifically, any information from the vial label that identifies the location in the colon that the biopsy came from, what was biopsied, e.g. polyps or area of inflammation and if polyps, how many specimens were placed in the vial. For example the vial may be labeled as "Ascending colon polyps X 2." It is not necessary to include information from the label such as the client's name and date specimen received in the path report field. - the number of fragments received in each vial. (This information helps to determine whether or not all polyps described in the procedure report are accounted for on the path report.) - the size of the fragments received. (This information helps to determine whether or not the polyp was large if not specified in the procedure report [see above for coding of the large adenoma field] and also helps determine whether or not there is concern for complete removal of a large polyp.) - any notes in the pathology report regarding whether or not the margins were clear for adenomas or cancerous lesions.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Complications of Procedure:	If there was a complication or unplanned event, please enter "Yes"; otherwise, enter "No/Unknown." A complication of a procedure (or adverse or unplanned event) is defined as an adverse event occurring in preparation for, during, or within 30 days after a procedure. See the Guidelines for Reporting Complications to DHMH document in CDB Help for further guidance on identifying and reporting complications.	Yes
		If yes, specify	Please use this field to document the complication that occurred. (See the latest HO Memo for further guidance re: reporting of complications to DHMH.)	Yes
		Complication Evaluation by DHMH	This field will be completed by DHMH staff after review of the case.	DHMH field
		Client Notified of Screening Results?	Was the client ever notified of the results **by your program**? Although providers may tell clients of findings immediately after the procedure, the client may not remember the information. Furthermore, if a biopsy was done, the results will not be available for several days after the procedure, so notification on the day of the procedure will not accurately reflect the findings. If a biopsy was done, be sure to wait until you have the pathology report or a report from the doctor summarizing the findings from **BOTH** the procedure and the pathologist, as well as the recall recommendation, before notifying the client. - "**Yes**" means you spoke to the client (by telephone or in person) or you sent the client a letter informing him/her of the results or both. Programs should send result letters to clients who have a colonoscopy, sigmoidoscopy, or imaging documenting the results and recall recommendation. (See the latest HO Memo re: case management guidance for notification.) - For positive screening results, a "**Yes**" means that you spoke to the client (by telephone or in person) or, if you were unable to reach the client by phone or in person after three attempts, that you sent the client a certified letter and s/he personally signed for receipt of the certified letter. - Check "**No**" in the CDB if you were unsuccessful in your attempts to notify the client by the above means. - It is important that the Program contact the client to make sure he/she has received the results and understands what he/she has been told. Check "**Yes**" only if you are sure that you notified the client of his/her results. If you attempted to notify the client but were unable to, check "**No**."	Yes
		Date Program Notified Client	This is the date that your Program notified the client, **not** the date that the doctor notified the client. This date cannot precede the date you received the results. This is a Benchmark. The goal is to notify the client within 7 days of receipt of all the results need for notification, that is the procedure report, pathology report (if a biopsy was done) and the provider's recall recommendation.	Yes
		Type of Notification	Mark here only the ways in which you *actually reached the client* to notify him/her of results. You may have tried numerous ways and these can be documented in the Notification Comments section or Nurse's Notes, but for this section, enter how the client was actually reached for notification. If you notified the client by more than one means, please check all the ways. **Note: In person, verbally is not the same as by telephone.**	No

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
3	Endoscopy or Imaging (DCBE, SCBE/ Virtual Col, etc.) Results	Notification Comments	Use this field to document anything about the notification such as attempts to notify, why the client is lost to follow-up, etc. - If there is a long delay in getting the results and you do contact the client in the meantime, you can document this here to clarify why there was a delay in getting the results and what efforts were made to keep the client informed during the delay. - If you are not able to notify the client, e.g., client has moved and left no forwarding address and is, therefore, lost to follow-up, you should document what efforts were made to contact the client.	No
4	Screening Summary Recommendations	Recommendations	Check one box that best describes the recommendations after screening*: - Screening was done; no cancer was found or suspected, and no further testing is recommended for that screening cycle. - Screening was done; no CRC cancer was found or suspected and no further CRC screening is needed but there were other findings, e.g., another type of cancer (metastatic endometrial cancer, not CRC) needing follow-up. Indicate the type of referral, e.g., GYN. - Additional testing is needed to complete the screening cycle due to, for example, an inadequate exam; specify what additional tests are recommended this cycle. - If CRC is detected or suspected: - Check the 4th box if further work-up is indicated. -Check the 5th box if no further work-up or treatment is needed (e.g., the cancer was in the polyp that was removed entirely during the colonoscopy). Either of these last two choices will take you to the CRC Post-Screening Form. *If a pre-screening exam or full physical exam was done but no CRC screening tests were done, the computer will still take you to this screen; skip past it if you have done no screening tests.	Yes
5	Cycle Closure—for those not going to Post Screening Form	Date Cycle Closed	Enter the date you close the cycle. Program staff should close a cycle when: 1) the client has completed all screening, diagnosis, and treatment procedures indicated/recommended for that cycle; 2) three months have elapsed since an inadequate colonoscopy without a repeat colonoscopy (cycle should close as No Cancer Suspected and a new cycle opened for the repeat colonoscopy to assure current information re: risks and symptoms); 3) six months have elapsed since the cycle start date with no screening procedures completed (cycle should close as No screening done, cancer status unknown and a new cycle started when the client is able to complete the screening); 4) one year has elapsed since the cycle start date for clients undergoing treatment (all clients who are receiving treatment services in the Program should be assessed at least yearly to see if they still meet the eligibility criteria for receiving treatment services in the Program); 5) the client has refused further screening, diagnosis, or treatment; 6) the client is lost to follow-up; 7) the client is ineligible for further screening, diagnosis, or treatment; 8) the client has chosen or been linked to another provider; or 9) the client dies.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
5	Cycle Closure—for those not going to Post Screening Form	Date Cycle Closed	When you close a cycle, consider whether the client needs to be discharged from the CRC module or from the program entirely (e.g., when a client is lost to follow-up or is deceased).	Yes
		Final Hierarchical Diagnosis	This is system generated. Final Hierarchical Diagnosis summarizes the cycle by reflecting the most advanced finding from all the procedures performed in that cycle. You do not have to write it on the client's form but it is good to check that it agrees with your knowledge of the client's findings and to check your data entry. If it does not agree, then you should go back and check your data entry to make sure you have not made a mistake in entering the findings. Refer to the Help menu for the definitions of the Final Hierarchical Diagnosis.	System generated
		Cycle Outcome	Please note that the choices for Cycle Outcome on each hard copy form do not include all the options for Cycle Outcome that you will see on the screen. The choices for Cycle Outcome at the end of the CRC Screening Form are only for cycles that ended with negative findings or incomplete work up of positive findings. Positive FOBTs without other testing, those with cancer suspected or confirmed, and those who were enrolled for diagnosis and treatment only, will proceed to the Post Screening Form where a different set of cycle outcomes will be available at the completion of that cycle. We have added a data entry "pop up box" to assist you in selecting the correct Cycle Outcome. For example, if the client only had an FOBT and you choose No Cancer Detected as Cycle Outcome, you will get a pop-up box asking if that is correct. **No cancer detected**: (NOCADETECT) - Adequate colonoscopy, no cancer found (however client may have other findings such as adenoma, hyperplastic polyp, inflammatory bowel disease, etc.). **No cancer suspected**: (NOCASUSP) - FOBT or FIT negative, no increased risk, no symptoms. - FOBT or FIT negative with sigmoidoscopy negative for cancer. - Adequate sigmoidoscopy negative for cancer; FOBT not done. - Inadequate examination (sigmoidoscopy, colonoscopy, or imaging) but no cancer was found or suspected on the inadequate exam, no repeat adequate colonoscopy was done within the cycle and FOBT negative or not done. - Adequate Imaging with no significant lesions seen on Imaging that need further work-up **Abnormal, cancer status unknown**: (ABNORMAL) - Abnormal findings suggestive of cancer without further work-up (e.g., Imaging that looked like cancer but client had no further testing; large polyp with dysplasia and person refuses surgery to rule out or confirm cancer) - FOBT or FIT positive, eligible for further screening/services by Program but no further work-up done - FOBT or FIT positive, inadequate colonoscopy (unless cancer found, then see above) - FOBT or FIT positive, inadequate imaging - FOBT or FIT positive, sigmoidoscopy negative or inadequate (unless cancer found) - FOBT of FIT negative, BUT client has either increased risk or symptoms and no colonoscopy done. - Inadequate exam on sigmoidoscopy, colonoscopy, or imaging (unless cancer found) in a client with increased risk or with symptoms, but no further work-up was performed this cycle.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
5	Cycle Closure--for those not going to Post Screening Form	Cycle Outcome	**No screening done, cancer diagnosis and treatment only:** (CADXTREAT) - Cycle started on a client previously diagnosed with cancer to have diagnosis and/or treatment paid for by Program **No screening done, cancer status unknown**: (NOSCRNING) - FOBT or FIT distributed but not returned. - No screening test (FOBT, sigmoidoscopy, colonoscopy, or imaging) performed.	Yes
		CRC Risk Based on Cycle Screening and Client and Family History	Please refer to the CRC-Risk Definitions in the CDB Help menu for guidance on risk at Cycle Closure. Please Note: 1) A client who entered the cycle as Average Risk, had all the recommended testing completed with NO significant findings of colorectal cancer, suspect cancer, adenomas or IBD, will be closed as "Average Risk"; 2) A client at Increased Risk at the start of the cycle because of family or personal history, will remain at Increased Risk at cycle closure, regardless of the findings of the screening tests; and 3) A client who has significant findings on this screening (colorectal cancer, suspect cancer, adenomas or IBD) will be at Increased Risk at Cycle Closure. Symptoms are NOT factored into the risk assessment. Also, a positive FOBT is a screening test result that increases the likelihood that the client may be found to have cancer but it does not put a person at increased risk of developing cancer and is therefore not a finding that should be considered when assessing risk at Cycle Closure.	Yes
		Screening Recall	Enter the number of months or years after the current screening procedure for each of the recall procedures recommended. The recall should be determined by the provider who performed the procedure and for procedures beyond an FOBT, should be included in the provider's written summary note after review of the pathology findings if a biopsy was done. If the recommended recall interval for the next screening does not fall within the guidelines specified in the CRC Minimal Elements (see CDB Help), the administrative case manager should contact the physician to discuss the case to determine if a change in the recall date is needed. The outcome of this discussion should be documented in the Recall and/or Closure Comments or in the Nurse's Notes in the CDB and should be documented in the client record. (See latest HO Memo regarding guidelines for case management of recommended recall intervals.) Once this page is saved, the recalls entered here are "locked" and cannot be updated or changed *from this page* . You will have to go to the Recall table, accessed via the Client Information page, to change the recall date or add a new recall procedure and date. If you or the provider change the recall after you have entered it in the CDB, put a note in the "Recall and/or Closure Comments" explaining why. If you change a recall date in the recall table you must change the date in the **Projected Recall Date** field in order for the client to appear on your recall report for the specified recall date. A date entered in the Actual Recall Date field will **NOT** trigger the system to notify you of that recall on recall reports. That field is only to specify why you actually initiated recall attempts for a given recall.	Yes

PG #	SECTION	FIELD	GUIDANCE	REQUIRED FIELD
5	Cycle Closure--for those not going to Post Screening Form	Recall and/or Closure Comments	This is a good place to document: - reasons for any changes in recall dates or recall methods, - reasons for closing a cycle as "abnormal, cancer status unknown" if eligibility is unknown, - problems encountered during the screening process that have not been documented elsewhere, or - any other notes that you think might be helpful in summarizing the screening cycle.	No