Maryland Department of Health and Mental Hygiene, Center for Cancer Surveillance and Control
Cancer Prevention, Education, Screening, and Treatment Program

Colorectal Cancer (CRC) Screening Form

Program Use Only

Jurisdiction:	**Client Identification**
Interviewer:	**CDB ID:** (system generated)
Outreach Worker:	Local ID: (optional)
Educator:	**Cycle Number:** (system generated)
Case Manager:	*Date of data entry into CDB:* (mm/dd/yyyy) / /
Interview Date: (mm/dd/yyyy) / /	**Sponsor**: Initials:

Patient Information

Last Name: Suffix: (Jr., etc.)	**First Name:** Middle**:**
Date of Birth: / / Age at Screening: (mm/dd/yyyy)	**SSN:** (last 4 digits)

History (from patient interview)

Client history of colorectal cancer?	☐ No ☐ Yes, date of diagnosis: ☐ Unknown
Client history of colon adenomatous polyps/adenoma?	☐ Yes, date of first diagnosis: ☐ No
	☐ Polyps, type not known ☐ Unknown

Client history of inflammatory bowel disease?   ☐ No   ☐ Unknown

☐ Yes, check one selection below and enter date of first diagnosis (onset):

☐ Ulcerative Colitis, date: _____   ☐ Crohn's Colitis, date: _____

☐ Both Ulcerative and Crohn's, date: _____   ☐ Unknown/not specified

Client history of: ☐ Ovarian or Endometrial Ca <age 50 yr   ☐ Pelvic Radiation   ☐ None

Family history of adenoma, polyp type unknown, or colorectal cancer in first-degree relative (parent, sibling, child)?

☐ Yes, specify relationship and youngest age at diagnosis (onset) below   ☐ No   ☐ Unknown

Colorectal Cancer		Adenoma/Polyp Type Unknown		
Relationship (e.g., mother, brother, son)	Age at onset	Relationship (e.g., mother, brother, son)	Age at onset	Indicate whether Adenoma or Polyp type unknown

Comments on CRC History:

CRC Risk based on client and family history:	☐ Average Risk ☐ Increased Risk
(Refer to CRC Minimal Clinical Elements)	

Symptoms

Does client have gastrointestinal symptoms possibly suggesting colorectal cancer?   ☐ No   ☐ Unknown

☐ Yes, specify symptoms below: *(check all that apply)*

☐ Lower abdominal pain   ☐ Bright red blood per rectum, bloody stools

☐ Marked change in bowel habits   ☐ Unexplained weight loss

☐ Other symptoms, specify:

Comments on Symptoms:

Previous Screening History

If client was previously tested for CRC outside of this Program, specify the test(s) and provide details: *(check all that apply)*

Test	Date	Results	Provider
☐ FOBT/FIT			
☐ Sigmoidoscopy			
☐ Colonoscopy			
☐ Barium Enema			
☐ Other (specify)			

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Client Name (Last, First):	ID:	Cycle #:

Other Medical History

Does client have history of: *(check all that apply below or 'None')* ☐ None of the following:

☐ Prior abdominal surgery ☐ Pacemaker ☐ Replacement heart valve ☐ Internal defibrillator

☐ Joint replacement ☐ Bleeding tendency ☐ Regular use of aspirin, NSAIDS, coumadin, anticoagulants

FOBT/FIT

Kit Given:	☐ Yes, **Type:** ☐ FOBT ☐ FIT ☐ No (*If No: Go next Section*)	**Date Given:** / /

Kit Returned: ☐ Yes ☐ No (*If No: Go to Screening Eligibility Section*)

Date Kit Returned: / /	**Date Results Received by Program:** / /

Kit Results: ☐ Positive ☐ Negative ☐ Other, specify:

Client Notified of Screening Results:	☐ Yes ☐ No (*If No: Go to Screening Eligibility Section*)

Date Program Notified Client: / / Notified by whom?

Type of Notification: *(check all that apply)* ☐ In-person, verbally ☐ In-person, in writing

☐ Letter/Regular mail ☐ Telephone ☐ Certified letter ☐ Other, specify:

Notification Comments:

Screening/Services Eligibility (Beyond FOBT)

Eligible for Screening/Services by Program (Beyond FOBT)?	☐ Yes ☐ Not applicable/Unknown (*Go to Cycle Closure*) ☐ No (specify reason below)

If ineligible, reason for ineligibility: ☐ Age ☐ Income ☐ Health insurance ☐ Residency
(check all that apply) ☐ Other, specify:

Screening/Diagnosis Payer: *(check all that apply)*	☐ CRF	☐ Medical Assistance	☐ Medicare
	☐ Commercial insurance	☐ Self	☐ Other, State
	☐ Charity care/uncompensated	☐ CDC	☐ Unknown
	☐ MCF	☐ Other, specify:	

Screening Recommended

(check all that apply)	Pre-Screening ☐	Physical Exam ☐	Sigmoidoscopy ☐	Colonoscopy ☐	DCBE ☐
Date Scheduled					
Date Rescheduled					
Provider					
Not Performed in Program: *(select reason)*	☐ Ineligible ☐ Refused ☐ Lost to follow-up ☐ Moved ☐ Chose other provider ☐ No longer recommended ☐ Other	☐ Ineligible ☐ Refused ☐ Lost to follow-up ☐ Moved ☐ Chose other provider ☐ No longer recommended ☐ Other	☐ Ineligible ☐ Refused ☐ Lost to follow-up ☐ Moved ☐ Chose other provider ☐ No longer recommended ☐ Other	☐ Ineligible ☐ Refused ☐ Lost to follow-up ☐ Moved ☐ Chose other provider ☐ No longer recommended ☐ Other	☐ Ineligible ☐ Refused ☐ Lost to follow-up ☐ Moved ☐ Chose other provider ☐ No longer recommended ☐ Other

☐ No screening recommended, specify details:

☐ See own doctor, specify details:

☐ Other screening recommended, specify details:

SKIP PATTERN INSTRUCTIONS:

If any exams or screening tests (other than initial FOBT) performed that were paid for by the program:	Go to page 3 to record findings
If FOBT was negative, client was 'average risk' per history, and no more tests/exams performed in program this cycle:	Go to Cycle Closure section
If no exams or screening tests (beyond FOBT) performed this cycle because client refused, lost to f/u, moved, chose other provider:	
If FOBT was positive and no additional tests done due to ineligibility:	Go to CRC Post Screening Evaluation Form to document follow-up
If FOBT was negative and client is 'increased risk' or symptomatic AND no additional tests done due to ineligibility:	

Colorectal Cancer (CRC) Screening Form

Client Name (Last, First):	**ID:**	**Cycle #:**

Eligible Clients: Results from Exam (if recommended)

Type of Exam: ☐ Physical exam ☐ Pre-Screening visit **Date of Exam:**   /   /

Provider: Date Results Received by Program: /   /

Significant Findings:

Client Notified of Exam Results: ☐ Yes   ☐ No (*Go to Cycle Closure Section*)

Date Client Notified: /   /   Notified by whom?

Type of notification (check all that apply*)*:   ☐ In-person, verbally   ☐ In-person, in writing

☐ Letter/Regular mail   ☐ Telephone   ☐ Certified letter   ☐ Other, specify:

Notification Comments:

Eligible Clients: Endoscopy or DCBE Results (if recommended)

Procedure: **Date Performed:**   /   /   Provider:

Biopsy Done:	☐ Yes	☐ No	☐ Not applicable (DCBE)
Was bowel prep adequate?	☐ Yes	☐ No	☐ Unknown
Was cecum reached, if colonoscopy?	☐ Yes	☐ No	☐ Unknown

Adequate Exam: ☐ Yes   ☐ No   **Date Results Received by Program:**   /   /

Findings:

(check all that apply)

☐ Confirmed cancer, specify type: _____
    Specify location: _____

☐ Presumed/Suspect cancer

☐ Adenoma, specify: Number: _____ Size of largest adenoma (in mm*): _____ Large? (Y/N/U)[+]_____

   Pathology:
   Histology of most advanced lesion: ☐ Tubular (least advanced)
                                               ☐ Tubulovillous
                                               ☐ Villous (most advanced)

   Were any of the adenomas called high-grade dysplasia on pathology, (high-grade dysplasia, severe dysplasia, carcinoma-in-situ, intramucosal carcinoma)?   ☐ Yes   ☐ No

   Were any of the adenomas described as "serrated"?   ☐ Yes   ☐ No

☐ Hyperplastic polyp(s), specify number: _____   ☐ Suspected Hyperplastic Polyposis

☐ Other polyp/polyp type not otherwise specified (e.g., identified by sight and no pathology):
   Number: _____   Size of largest polyp (in mm*): _____
   Type of polyp/reason 'other': _____   ☐ Polyp with unknown pathology

☐ Inflammatory Bowel Disease (IBD) *(check one of the following options)*:
   ☐ Ulcerative colitis (UC)   ☐ Crohn's colitis   ☐ UC & Crohn's colitis   ☐ IBD type unknown

☐ Diverticuli

☐ Hemorrhoids

☐ Other, specify: _____
   (e.g., healed resection scar, melanosis coli, "inflammation," cannot rule out cancer, etc.)

☐ Normal, none of the above findings

*To get mm, multiply cm X 10   [+]Indicate if any adenoma size ≥ 10 mm (1 cm) or report implied 'large'

Comments on Findings:

Complications of Procedure: ☐ Yes   ☐ No/Unknown

If yes, specify:

Client Notified of Screening Results: ☐ Yes   ☐ No (*Go to Cycle Closure Section*)

Date Program Notified Client: /   /   Notified by whom?

Type of Notification: *(check all that apply)*   ☐ In-person, verbally   ☐ In-person, in writing

☐ Letter/Regular mail   ☐ Telephone   ☐ Certified letter   ☐ Other, specify:

Notification Comments:

If additional screening procedures recommended, record on "Screening Recommended" table on page 2 and complete CRC Supplemental Procedure Form for each procedure done.

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Client Name (Last, First):	**ID:**	**Cycle #:**

Eligible Clients: Screening Summary Recommendations

Recommendations: *(check all that apply)*

☐ No CRC cancer detected/suspected, recall for routine screening.

☐ No CRC cancer detected/suspected, refer for other findings.   Refer to: _____

☐ No CRC cancer detected/suspected, other recommendations. Specify: _____

☐ *CRC detected/suspected, refer for further evaluation/treatment for cancer.

☐ *CRC detected, no further evaluation/treatment needed. Recall for routine screening.

Note: *If Cancer detected or suspected, go to Colorectal Cancer Post Screening Evaluation Form; all others go to Cycle Closure.*

Cycle Closure

Date Cycle Closed: _____ / _____ / _____

Final Hierarchical Diagnosis: (system generated)

Cycle Outcome:
(check one)

☐ No cancer detected

☐ No cancer suspected

☐ Abnormal, cancer status unknown

☐ No screening done, cancer status unknown

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

Screening Recall:
(check all that apply)

☐ Fecal test:
  ☐ 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 Comments: