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: **SSN:**
(mm/dd/yyyy) (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

Relationship (e.g., mother, brother, son)	Age at onset

Adenoma/Polyp Type Unknown

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: *(check all that apply)* ☐ Age ☐ Income ☐ Health insurance ☐ Residency
☐ Other, specify:

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

Screening Recommended

(check all that apply)	**Pre-Screening** ☐	**Physical Exam** ☐	**Sigmoidoscopy** ☐	**Colonoscopy** ☐	**Imaging** ☐ **Type:**
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 Imaging (DCBE/SCBE/Virtual Col.,etc) Results (if recommended)

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

Biopsy Done: ☐ Yes ☐ No ☐ Not applicable (IMAGING)

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): _____

☐ Imaging: Projected date (mm/yyyy): _____

☐ DCBE ☐ SCBE ☐ Virtual Colonoscopy, ☐ Other 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: