



Polyp Surveillance Data Collection Form

Eligible Patients: Have undergone a colonoscopy with complete removal of at least one or more polyps

Past Medical History

1. Inflammatory bowel disease

- No / Not Documented Yes ⇒ **STOP HERE – Patient is not eligible**

2. Inherited or other polyposis syndrome

- No / Not Documented Yes ⇒ **STOP HERE – Patient is not eligible**

3. Colorectal cancer (in past medical history or found on this colonoscopy)

- No / Not Documented Yes ⇒ **STOP HERE – Patient is not eligible**

Colonoscopy Report

4. Exam Date

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5. Was the colonoscopy aborted before the end of the procedure?

- No
- Yes, the colonoscopy was aborted before the cecum was reached
- Yes, the colonoscopy was aborted after the ceum was reached (e.g., on withdrawal)

6. Reason(s) colonoscopy was aborted: (*check all that apply*)

- Not applicable – colonoscopy was not aborted
- Insufficient bowel preparation
- Severe colitis, diverticulitis or obstruction
- Inadequate sedation or patient discomfort or intolerance of procedure
- Procedural complication or adverse cardiovascular event.
- Other reason documented for aborting the procedure

7. Was the cecum successfully intubated (or ileocolonic anastomosis reached)?

- No Yes Unknown

Colonoscopy Report (continued)

8. Landmarks used to verify cecal intubation: *(check all that apply)*

- Not applicable – no cecal intubation
- Appendiceal orifice
- Ileocecal valve
- Terminal ileum
- Transabdominal illumination*
- Ileocolonic anastomosis
- Cecal intubation stated, but specific landmark(s) not specified

*Note: transabdominal illumination alone is an insufficient landmark to verify cecal intubation

9. Was a cecal landmark photographed?

- Yes No Unknown

10. The bowel preparation was documented as: *(check all that apply)*

- Not applicable - the quality of the bowel preparation was not documented
- Excellent
- Good
- Fair
- Poor
- Adequate
- Inadequate
- Adequate to identify polyps > 5mm
- Inadequate to identify polyps > 5mm

Polyp Findings at Time of Colonoscopy

11. The location of each polyp removed was described by the endoscopist

- Yes No / Not Documented

12. The size of each polyp removed was described by the endoscopist

- Yes, in millimeters (mm) or centimeters (cm)
- Yes, as small / medium / large, etc.
- No / Not Documented

13. The gross morphology of each polyp removed was described by the endoscopist

- Yes No / Not Documented

Notification of Results

21. Report of results and follow-up interval to primary care provider: $\frac{\text{M}}{\text{M}} / \frac{\text{D}}{\text{D}} / \frac{\text{Y}}{\text{Y}} \frac{\text{Y}}{\text{Y}} \frac{\text{Y}}{\text{Y}}$

- No report to primary care provider documented
- Patient documented as not having a primary care provider

22. Report of results and follow-up interval to referral source: $\frac{\text{M}}{\text{M}} / \frac{\text{D}}{\text{D}} / \frac{\text{Y}}{\text{Y}} \frac{\text{Y}}{\text{Y}} \frac{\text{Y}}{\text{Y}}$

- No report to referral source
- Referral source is the same as the primary care provider
- Patient was an internal referral

23. Report of results and follow-up interval to patient: $\frac{\text{M}}{\text{M}} / \frac{\text{D}}{\text{D}} / \frac{\text{Y}}{\text{Y}} \frac{\text{Y}}{\text{Y}} \frac{\text{Y}}{\text{Y}}$

- No report to patient