Colorectal Cancer (CRC) Post Screening Evaluation Form

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

If patient with cancer was not referred for further work-up or treatment go to ‘Summary of Diagnostic Work-up and Treatment of Cancer’ section on page two, all others proceed to ‘Program Eligibility’ section below.

**Program Eligibility**

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

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

**Ineligible Client (Complete through Cycle Closure section)**

<table>
<thead>
<tr>
<th>Reason for Ineligibility (check all that apply):</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Age</td>
</tr>
<tr>
<td>[ ] Income</td>
</tr>
<tr>
<td>[ ] Health insurance</td>
</tr>
<tr>
<td>[ ] Residency</td>
</tr>
<tr>
<td>[ ] Other, specify:</td>
</tr>
</tbody>
</table>

**Was ineligible client referred elsewhere for diagnosis/treatment?**

- [ ] Yes, referred to: __________
- [ ] No

**Ineligible Client Outcome (check only one):**

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

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

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

If adenoma required surgery, specify treatment status:

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

**Cancer, specify type:**

If cancer required surgery, specify treatment status:

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

Comments:

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

<table>
<thead>
<tr>
<th>Date cycle closed: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cycle Outcome:</td>
</tr>
<tr>
<td>[ ] Cancer detected</td>
</tr>
<tr>
<td>[ ] No cancer suspected</td>
</tr>
<tr>
<td>[ ] No cancer detected</td>
</tr>
<tr>
<td>[ ] Abnormal, cancer status unknown</td>
</tr>
</tbody>
</table>

**CRC risk based on cycle screening and client and family history:**

- [ ] Average risk
- [ ] Increased risk

**Screening Recall:**

- [ ] Fecal test:
  - [ ] FOBT or FIT, in ___ month/years (circle one).
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Projected date (mm/yyyy): __________
  - [ ] DCBE, in ___ month/years (circle one).
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Sigmoidoscopy, in ___ month/years (circle one).
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Colonoscopy, in ___ month/years (circle one).
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Other, in ___ month/years (circle one).
  - [ ] Projected date (mm/yyyy): __________
  - [ ] Projected date (mm/yyyy): __________

- [ ] If Other, specify:  

If no recall, complete Client Discharge Form.

Recall and/or Closure Cycle Comments:
# Colectoral Cancer (CRC) Post Screening Evaluation Form

**Client Name (Last, First):**

**ID:**  

**Cycle #:**

## Eligible Client

**Diagnosis/Treatment Payer:** (check all that apply)

- CRF
- Medical Assistance
- Medicare
- Commercial insurance
- Self
- Other, State
- Charity care/uncompensated
- CDC
- MCF
- Unknown
- Other, specify:

**Was eligible client referred for evaluation and/or treatment?**

- Yes  
  Referral to: ____________________________  
  Date of Referral appointment: __/__/__

- No, explain: ____________________________

**Were additional procedures or surgeries completed?**

- Yes (Complete a CRC Supplemental Procedure Form)
- No

**Final Hierarchical Diagnosis (system generated):**

**Status of Diagnosis:**

- Complete
- Died
- Chose other provider
- Refused
- Lost to follow-up
- Treatment only
- Moved
- Pending final diagnosis
- Unknown

**Date of Diagnosis:** __/__/__

## Summary of Diagnostic Work-up and Treatment of Cancer

**Was/is cancer treatment recommended?**

- Yes, completed during screening/diagnostic work-up
- Yes, further treatment needed
- No

**Treatment Type/Comments:** *(Include polypectomy, surgery, radiation, chemo, etc.)*

**Date first treatment began:** __/__/__

**Treatment Status:**

- Started/completed
- Deceased
- Lost to follow-up
- Chose other provider
- Refused
- Unknown
- Moved
- Other, specify:

**Tumor**

<table>
<thead>
<tr>
<th>Nodes</th>
<th>Metastases</th>
<th>Stage</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1</td>
<td>Positive</td>
<td>0</td>
</tr>
<tr>
<td>T2</td>
<td>Positive</td>
<td>I</td>
</tr>
<tr>
<td>T3</td>
<td>Negative</td>
<td>II</td>
</tr>
<tr>
<td>T4</td>
<td>Negative</td>
<td>III</td>
</tr>
<tr>
<td>Tis</td>
<td>Unknown</td>
<td>IV</td>
</tr>
</tbody>
</table>

**Hospitalized:**

- No
- Unknown
- Date of first admission: __/__/__

- Yes, hospital:

**Hospice:**

- No
- Unknown
- Date of first service: __/__/__

- Yes, facility:

## Cycle Closure (for Eligible Clients)

**Date Cycle Closed:** __/__/__

**Cycle Outcome:**

- Cancer detected
- No cancer detected
- Abnormal, cancer status unknown
- No screening done, cancer dx and tx only

**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).
  - DCBE, in ____ month/years (circle one).
- Colonoscopy, in ____ month/years (circle one).
- If Other, in ____ month/years (circle one).

- Sigmoidoscopy, in ____ month/years (circle one).
- Other, in ____ month/years (circle one).

**Projected date (mm/yyyy):**

- If Other, specify:

**Recall and/or Closure Comments:**