Version Date: 07/01

Participant ID Number

Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

MEDICAL RECORD ABSTRACT FORM TREATMENT INFORMATION – COLORECTUM (TIC2/TCQ2)

1. **Date Abstracted:** _____
   Month Day Year

2. **Abstractor ID#:** ___ ___ ___ ___

3. **CTR ID:** ___ ___ ___ ___

4. **Study Year T0-T13:** ___ ___

5. **Purpose of Abstract:**
   ○ Initial abstract
   ○ Re-abstract for QA

FOR OFFICE USE ONLY

6. **Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)**
   ○ Form Receipted into SMS
   ○ Manual Review Completed

Data Entry of Non-Scannable Items:
○ Completed
○ None Required

Data Retrieval:
○ Attempted
○ None Required

Disposition:
○ Interim Complete (ICM)
○ Final Complete (FCM)
○ Final Incomplete (FIC)

PART A: INITIAL TREATMENT INFORMATION

1. SURGICAL TREATMENT FOR COLORECTAL CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

PROCEDURE #	1	2	3	4
TYPE OF SURGICAL PROCEDURE **(SEE SURGICAL PROCEDURE CODES BELOW. IF OTHER, SPECIFY)**	_____ **SPECIFY**	_____ **SPECIFY**	_____ **SPECIFY**	_____ **SPECIFY**
DATE OF SURGERY (MO.-DAY-YEAR)				

SURGICAL PROCEDURE CODES

01 = Local excision (includes local transanal excision)
03 = Surgical resection with reanastomosis
04 = Surgical resection with colostomy
06 = Bypass surgery or palliative resection
07 = Cryosurgery
08 = Lymphadenectomy/Lymph node sampling
09 = Appendectomy (for appendiceal primaries only)
10 = Laser ablation
88 = Other (SPECIFY)

2. RADIATION TREATMENT FOR COLORECTAL CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

TREATMENT #	1	2
DATE RADIATION TREATMENT BEGAN (MO.-DAY-YEAR)		

3. CHEMOTHERAPEUTIC TREATMENT FOR COLORECTAL CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

TREATMENT #	1	2
DATE CHEMOTHERAPEUTIC TREATMENT BEGAN (MO.-DAY-YEAR)		

4. OTHER TYPE OF TREATMENT FOR COLORECTAL CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

TREATMENT #	1	2
DATE OTHER TREATMENT BEGAN (MO.-DAY-YEAR)		

5. ANY LOCAL OR REGIONAL RESIDUAL DISEASE LEFT AFTER SURGERY:

○ No

○ Yes – Microscopic

○ Yes – Gross Tumor

○ Not applicable

○ Unknown

PART B: PHYSICIAN/HOSPITAL LOCATION INFORMATION

6. PHYSICIAN FOR TREATMENT:

a. Name: _____

Address: _____
City State ZIP Code

Telephone: (___) _____ **Medical Record/Chart #** _____

b. Name: _____

Address: _____
City State ZIP Code

Telephone: (___) _____ **Medical Record/Chart #** _____

7. HOSPITAL OR CLINIC FOR TREATMENT:

a. Name: _____

Address: _____
City State ZIP Code

Telephone: (___) _____ **Medical Record/Chart #** _____

b. Name: _____

Address: _____
City State ZIP Code

Telephone: (___) _____ **Medical Record/Chart #** _____

8. COMMENTS:

○ No

○ Yes (SPECIFY)

Item #	Comments

○ (CONTINUED)