|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Organizational Identifiers** |  |  |
|  | VAMC  CONTROL  QIC  BEGDTE  REVDTE | Facility ID  Control Number  Abstractor ID  Abstraction Begin Date  Abstraction End Date | Auto-fill  Auto-fill  Auto-fill  Auto-fill  Auto-fill |  |
|  |  | **Patient Identifiers** |  |  |
|  | SSN  PTNAMEF  PTNAMEL  BIRTHDT  SEX  MARISTAT  RACE | Patient SSN  First Name  Last Name  Birth Date  Sex  Marital Status  Race | Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: no change  Auto-fill: can change  Auto-fill: no change  Auto-fill: no change |  |
|  |  | **Index Colonoscopy** |  |  |
| 1 | indexdt | Enter the date of the index colonoscopy completed during the timeframe from 1/01/2017 through 12/31/2017. | mm/dd/yyyy  **Computer will pre-fill from pull list**   |  | | --- | | >= 01/01/2017 and <= 12/31/2017 | | Computer will pre-fill the date of the index colonoscopy completed in during the specified timeframe. |
| 2 | indxcol | On (computer to display indexdt), is there documentation of the index colonoscopy in the medical record?  1. Yes  2. No | 1,2  If 1, auto-fill othindcol as 95, othcoldt as 99/99/9999, and go to colinpt; else go to othindcol | Search procedure reports, surgical reports, and progress notes for documentation that a colonoscopy was performed on the date entered in INDEXDT. |
| 3 | othindcol | During the timeframe from (computer to display indexdt – 180 days to indexdt + 180 days), is there documentation a colonoscopy was performed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if indxcol = 1  **\*If 2, go to pretac** | Search procedure reports, surgical reports, and progress notes for documentation that a colonoscopy was performed within 180 days prior to or after the pre-filled index colonoscopy date. |
| 4 | othcoldt | Enter the date of the most recent colonoscopy completed during the timeframe from (computer to display indexdt – 180 days to indexdt + 180 days). | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if  indxcol = 1   |  | | --- | | <= 180 days prior to indexdt and <= 180 days after indexdt and < = stdyend | | If more than one colonoscopy was performed during the timeframe, enter the date of the most recent colonoscopy. |
| 5 | colinpt | Was the index colonoscopy performed during an inpatient hospitalization at a VAMC?  1. Yes  2. No | 1,2 | If the index colonoscopy was performed during an inpatient hospitalization at any VAMC, answer “1”. If the colonoscopy was performed as an outpatient procedure prior to an inpatient admission, answer “2.” For example, patient is scheduled for outpatient colonoscopy and has a complication during the procedure requiring admission; answer “2.” |
| 6 | colnrpt | Was the colonoscopy procedure report/note found in the medical record?  3. Procedure report found in CPRS  4. Procedure report found in VISTA imaging  99. Procedure report not found in medical record | 3,4,99  **\*If 99, go to pretac**  **Warning if 99 and colinpt = 1** | If the actual colonoscopy report/note is not found in CPRS or VISTA imaging, enter “99”.  Suggested data sources: Notes, consults, procedures, VISTA imaging |
| 7 | colnrp\_txt | Enter the note title of the colonoscopy procedure report. | Text  (limit 150 characters) | Enter the local note title as documented in the record. Examples include, but are not limited to:  Local Title: Colonoscopy Procedure Note  Local Title: Co-GI Consult Procedure Note |
| 8 | anescoln | Is there documentation that an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) was present at the time of the index colonoscopy to sedate the patient for the procedure?  1. Yes  2. No | 1,2 | **The intent of this question is to determine if the patient was sedated for the procedure under the supervision of an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA).** This type of procedural sedation may be documented as Monitored Anesthesia Care (MAC).  Look at the colonoscopy report and any peri-procedural notes (including sedation records) available in the medical record for documentation of procedural sedation.  **Note:** may see the terms “anesthesia,” “anesthesiologist,” “CRNA (Certified Registered Nurse Anesthetist)”, “Propofol” (under medications), “See anesthesia note,” or “MAC (monitored anesthesia care).”  If any of the above terms are documented, select “Yes.”  If none of these terms are present, select “No.” |
| 9 | colind1 | Is there physician/APN/PA documentation of a specific reason (indication) the index colonoscopy was performed?  1. Yes  2. No | 1,2  If 2, auto-fill crcscrn as 95, highrsk as 95, nonscrn as 95, and go to anatext | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason (indication) may be used (e.g., pre-operative diagnosis).  Reasons ( indication) for performing a colonoscopy may include, but are not limited to:   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Screening only * Surveillance, NOS * Symptoms such as bleeding, change in bowel habits, abdominal pain |
| 10 | crcscrn | Is there physician/APN/PA documentation the index colonoscopy was performed for average-risk (routine) screening only?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if colind1 = 2  If 1, go to anatext | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  In order to answer “1”, the physician/APN/PA documentation must clearly indicate the colonoscopy was performed for average-risk screening only. It is not necessary to see the term “average-risk”.  If documentation indicates the colonoscopy was performed for routine screening, select “1”.  If documentation indicates the colonoscopy was performed due to symptoms such as bleeding, change in bowel habits, abdominal pain or any of the high-risk screening/surveillance indications (e.g., family or personal history colorectal cancer, family or personal history polyps, inflammatory bowel disease, Crohn’s disease, ulcerative colitis, high risk, or surveillance), enter “2”.  **If the indication documented in the colonoscopy report/procedure note is conflicting (i.e., average-risk screening and rectal bleeding), enter “2”.** |
| 11 | highrsk1  highrsk2  highrsk3  highrsk4  highrsk5  highrsk6  highrsk7  highrsk95  highrsk99 | Select all high-risk screening or surveillance reasons/indications documented in the colonoscopy report/procedure note.  **Indicate all that apply:**  1. Family history of colorectal cancer  2. Family history of colorectal adenomas or polyps  3. Personal history of polyps  4. Personal history of colorectal cancer  5. Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis  6. High risk, NOS  7. Surveillance, NOS  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if colind1 = 2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason may be used (e.g., pre-operative diagnosis).  High-risk screening or surveillance involves testing patients that previously had colorectal cancer or are at increased risk for colorectal cancer. |
| 12 | nonscrn | Is there physician/APN/PA documentation that the index colonoscopy was performed for a non-screening diagnostic indication (bleeding, positive FOBT, anemia, diarrhea, constipation, abdominal pain, etc.)?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if colind1 = 2   |  | | --- | | Hard edit: If highrsk99 = -1 cannot = 2 | | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason may be used (e.g., pre-operative diagnosis).  **Non-screening diagnostic indication** = person has symptoms of a condition or disease.  If any non-screening diagnostic indication is documented by the physician/APN/PA as the reason for performing the colonoscopy, answer “1”. |
| 13 | anatext | Is there documentation of the anatomic **extent reached** during the index colonoscopy?  1. Yes  2. No | 1,2  If 2, auto-fill anareach as 95, and go to qualprep | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Anatomic extent reached may be documented under a heading (e.g., **Extent of Examination:** Cecum) or in body of procedure report/note. For example:  **Description of Procedure and Findings:** Informed consent was obtained. Rectal examination by finger was unremarkable. The scope was introduced all the way up to the cecum without any difficulty. |
| 14 | anareach | Is there documentation the cecum, appendix, appendiceal orifice, ileum, or small bowel was reached during the index colonoscopy?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if anatext = 2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  If there is documentation that the cecum, appendix, appendiceal orifice, ileum, or small bowel was reached during the colonoscopy, answer “1”. |
| 15 | qualprep | Is there documentation of the **quality of bowel preparation** in the index colonoscopy report?  1. Yes  2. No | 1,2  If 2, auto-fill poorprep as 95, prep as 95, and go to bbpsprep | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Quality of preparation may be documented under a heading or in the body of the procedure report/note. In order to answer “yes”, the header or statement must clearly refer to the overall quality of the bowel preparation. Disregard statements about visual quality as the scope is advanced through different sections of the colon that occur in the body rather than header of the report (i.e., are descriptors of the endoscopy rather than a summary assessment of overall preparation quality).  **Examples include but are not limited to:**  “Parts of the transverse colon were obscured by stool” or “The cecum was adequate after extensive cleaning.”  However, the endoscopist may write an overall prep assessment such as “The quality of the preparation was excellent except the cecum was poor” which is acceptable.  **Exclude:** Documentation of Boston Bowel Prep Scale |
| 16 | poorprep | Is there any mention of the bowel preparation being suboptimal, poor, or inadequate on the index colonoscopy?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if qualprep = 2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  If there is any mention that the quality of bowel preparation was suboptimal, poor, or inadequate (or similar term indicating the prep was unsatisfactory), answer “1”. |
| 17 | prep1  prep2  prep3  prep4  prep5  prep95  prep99 | Indicate the quality of bowel preparation documented in the procedure report/note.  **Indicate all that apply:**  1. Adequate (or satisfactory)  2. Good (or excellent)  3. Fair  4. Inadequate (or unsatisfactory)  5. Suboptimal (or poor)  95. Not applicable  99. None of the above or unable to determine | 1,2,3,4,5,95,99  Will be auto-filled as 95 if qualprep = 2  Cannot enter 99 with any other number  Cannot enter 1 or 2 with 3, 4, or 5 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Select the value(s) that indicate the quality of bowel preparation documented in the procedure report/note. If the term used to describe the quality of bowel preparation is not listed or is not similar to one of the terms listed, select “99”.  If bowel prep quality documentation is conflicting (e.g. adequate except cecum was poor), select “99”. |
| 18 | bbpsprep | Was the Boston Bowel Preparation Scale (BBPS) used to document the quality of bowel preparation?   1. Yes 2. No | 1,2  If 2, go to indbiop | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  The BBPS requires a score be assigned to each segment (right (cecum and ascending), transverse, left (descending, sigmoid and rectum)) of the colon. The segment scores range from 0 – 3 and are summed for a total BBPS score ranging from 0 -9. Segment points are assigned by the endoscopist as follows:  0 = unprepared colon segment with mucosa note seen due to solid stool that cannot be cleared  1 = Portion of mucosa of the colon segment seen, but other areas of the colon segment not well seen due to staining, residual stool and/or opaque liquid.  2 = Minor amount of residual staining, small fragments of stool and/or opaque liquid, but mucosa of colon segment seen well.  3 = Entire mucosa of colon segment seen well with no residual staining, small fragments of stool or opaque liquid.  If there is documentation the BBPS was used to document the quality of bowel preparation, select “1”. |
| 19 | bbpsr  bbpst  bbpsd | Enter the BBPS score for each colon segment documented in the colonoscopy report/procedure note.   |  |  | | --- | --- | | **Colon Segment** | **Score**  Whole numbers  0 – 3  Abstractor may enter zz | | 1. Right colon (ascending) |  | | 1. Transverse colon |  | | 1. Left colon (descending) |  | | | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  **Enter the BBPS score for each colon segment documented in the colonoscopy report/procedure note.**  If the score for a colon segment is not documented enter zz. |
| 20 | bbpstot | Enter the total BBPS score documented in the colonoscopy report/procedure note. | Whole numbers  0 -9  May enter zz | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Enter the BBPS total score documented in the colonoscopy report/procedure note.  If the total BBPS score is not documented in the colonoscopy report/procedure note, enter zz. |
| 21 | indbiop | Was a biopsy or other tissue removal (e.g., polypectomy) performed during the index colonoscopy (computer to display indexdt?  1. Yes  2. No  99. Unable to determine | 1,2  If 2 or 99, auto-fill indbiop as 95,and go to colnordt | **Review the colonoscopy procedure note/report to determine if a biopsy or other tissue removal (polypectomy) was performed during the procedure.**  If the colonoscopy report/procedure note is in the record and there is documentation a biopsy or other tissue removal (polypectomy) was performed, enter “1”.  If the colonoscopy report/procedure note is in the record and there is no documentation a biopsy or other tissue removal (polypectomy) was performed, enter “2”.  If the colonoscopy report is not available in the record and no other documentation indicates if a biopsy or other tissue removal (e.g., polypectomy) was performed, enter “99”.  Suggested data sources (CPRS and scanned documents): Colonoscopy report, Colonoscopy procedure note |
| 22 | indbiop1  indbiop2  indbiop3  indbiop95  indbiop99 | Do pathology results from biopsy/tissue removal show any of the following?  Indicate all that apply:   1. Adenoma or adenomatous polyp of the colon or rectum 2. Cancer, carcinoma, or adenocarcinoma of the colon or rectum 3. Inflammatory bowel disease (IBD, ulcerative colitis, or Crohn’s disease)   95. Not applicable   1. None of the above | 1,2,3,95,99  Will be auto-filled as 95 if indbiop = 2 or 99 | **Suggested data source: Pathology report** |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 23 | colnordt | For the colonoscopy performed on (computer display indexdt), enter the earliest date the index colonoscopy was ordered by the physician/APN/PA. | mm/dd/yyyy  Abstractor may enter 99/99/9999   |  | | --- | | <= 1 year prior indexdt and < indexdt | | Start by looking at the physician orders for the index colonoscopy. If documentation is available, enter the earliest date the colonoscopy was ordered. If no information is available in the physician orders, review the consult request and clinic notes to determine the date the colonoscopy was requested by the physician/APN/PA.  Enter the earliest date the index colonoscopy was ordered by the physician/APN/PA.  Suggested data sources: consult request, clinic notes, physician orders |
| 24 | ordind | Is there documentation by the referring physician/APN/PA of a specific reason (indication) the index colonoscopy was ordered?  1. Yes  2. No | 1,2  If 2, auto-fill crcscrn2 as 95, ordrsk as 95, ordiag as 95, and go to lifexpec | Look for documentation of a specific reason (indication) the colonoscopy was ordered in the progress notes (or consult request) of the physician/APN/PA that referred the patient for the colonoscopy.  **Reasons ( indication) for performing a colonoscopy may include, but are not limited to:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS * Symptoms such as bleeding, change in bowel habits, abdominal pain * Screening only |
| 25 | crcscrn2 | Is there documentation by the referring physician/APN/PA that the index colonoscopy was ordered for average-risk (routine) screening only?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if ordind = 2  If 1, go to lifexpec | In order to answer “1”, the physician/APN/PA that referred the patient for the colonoscopy must clearly indicate the colonoscopy was ordered for average-risk screening only.  It is not necessary to see the term “average-risk”.  If documentation indicates the colonoscopy was ordered for routine screening, select “1”.  If documentation indicates the colonoscopy was ordered due to symptoms such as bleeding, change in bowel habits, abdominal pain or any of the high-risk screening/surveillance indications listed below, enter “2”.  **High Risk Screening/Surveillance Indications:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS |
| 26 | ordrsk1  ordrsk2  ordrsk3  ordrsk4  ordrsk5  ordrsk6  ordrsk7  ordrsk95  ordrsk99 | Select all high-risk screening or surveillance indications documented by the ordering physician/APN/PA.  Indicate all that apply:  1. Family history of colorectal cancer  2. Family history of colorectal adenomas or polyps  3. Personal history of polyps  4. Personal history of colorectal cancer  5. Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis  6. High risk, NOS  7. Surveillance, NOS  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if ordind = 2 | Other terms for reason may be used (e.g., pre-operative diagnosis).  High-risk screening or surveillance involves testing patients that previously had colorectal cancer or are at increased risk for colorectal cancer.  **Reasons ( indication) for ordering a colonoscopy may include, but are not limited to:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS |
| 27 | ordiag | Was the index colonoscopy ordered for a non-screening diagnostic indication (bleeding, anemia, positive FOBT, diarrhea, constipation, abdominal pain, etc.)?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if ordind = 2  **If 1 or 2, go to lifexpec**   |  | | --- | | Hard edit: If ordrsk99 = -1 cannot = 2 | | **Non-screening diagnostic indication = person has symptoms of a condition or disease**  **If any non-screening diagnostic indication is documented by the physician/APN/PA as the reason for ordering the colonoscopy, answer “1”.** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 28 | pretac | Prior to the date of the index colonoscopy on (computer to display indexdt), is there evidence in the record that the patient had a total abdominal colectomy?  1. Yes  2. No | 1,2 | **Total abdominal colectomy** = Complete removal of the colon including the rectum |
| 29 | lifexpec | During CY2016 or CY2017, is there documentation that the patient’s life expectancy is less than 6 months?   1. Yes 2. No | 1,2 | Patient’s life expectancy of less than six months must be documented on the problem list or in the computer field “health factors,” without exception. |
|  |  | **Non-Index Colonoscopy** |  |  |
| 30 | nonindt1 | Enter the date of the most recent non-index colonoscopy performed prior to the index colonoscopy. | Mm/dd/yyyy  **Computer will pre-fill date of most recent non-index colonoscopy**  **\*If null, go to colfobt**   |  | | --- | | <= 10 years prior to indexdt and < indexdt | | Computer will pre-fill the date of the most recent non-index colonoscopy performed within 10 years prior to the index colonoscopy. |
| 31 | noncol1 | On (computer to display nonindt1), is there documentation that the non-index colonoscopy was performed?  1. Yes  2. No | 1,2  If 1, auto-fill othnon1 as 95, actnondt1 as 99/99/9999, and go to pcolnva4 | **Non-index colonoscopy** = colonoscopy performed prior to the index colonoscopy  Search procedure reports, surgical reports, and progress notes for documentation that a non-index colonoscopy was performed on the date entered in NONINDT1. Reports may also be found in VISTA Imaging. |
| 32 | othnon1 | During the timeframe from (computer to display nonindt1 – 180 days to nonindt1 + 180 days), is there documentation a non-index colonoscopy was performed?  1. Yes  2. No  95. Not applicable | 1,\*2,95  Will be auto-filled as 95 if noncol1= 1  **\*If 2, go to colfobt** | Search procedure reports, surgical reports, and progress notes for documentation that a non-index colonoscopy was performed within 180 days prior to or after the pre-filled non-index colonoscopy date.  Reports may also be found in VISTA Imaging. |
| 33 | actnondt1 | Enter the date of the most recent non-index colonoscopy completed during the timeframe from (computer to display nonindt1 – 180 days to nonindt1 + 180 days). | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if noncol1 = 1   |  | | --- | | <= 180 days prior to or after nonindt1 | | If more than one non-index colonoscopy was performed within 180 days prior to or after the pre-filled non-index colonoscopy date, enter the date of colonoscopy performed most immediately prior to the index colonoscopy. |
| 34 | pcolnva4 | Was the non-index colonoscopy performed at a VAMC?  1. Yes  2. No | 1,\*2  \*If 2, go to nonindt2 | If the non-index colonoscopy was performed at a VAMC, enter “1”.  If the non-index colonoscopy was performed outside the VHA, enter “2”. |
| 35 | noninpt1 | Was the non-index colonoscopy performed during an inpatient hospitalization at a VAMC?  1. Yes  2. No | 1,2 | If the non-index colonoscopy was performed during an inpatient hospitalization at any VAMC, answer “1”.  If the non-index colonoscopy was performed as an outpatient procedure prior to an inpatient admission, answer “2.” For example, patient is scheduled for outpatient colonoscopy and has a complication during the procedure requiring admission; answer “2.” |
| 36 | colnrpt2 | Was the non-index colonoscopy procedure report/note found in the medical record?  3. Procedure report found in CPRS  4. Procedure report found in VISTA imaging  99. Procedure report not found in medical record | 3,4,99  If 99, go to nonindt2 as applicable  **Warning if 99 and pcolnva4 or**  **noninpt1 = 1** | If the actual non-index colonoscopy report is not found in CPRS or VISTA imaging, enter “99”.  Suggested data sources: Notes, consults, procedures, VISTA imaging |
| 37 | ncolnrp\_txt | Enter the note title of the non-index colonoscopy procedure report. | Text  (limit 150 characters) | Enter the local note title as documented in the record. Examples include, but are not limited to:  Local Title: Colonoscopy Procedure Note  Local Title: Co-GI Consult Procedure Note |
| 38 | anescoln2 | Is there documentation that an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) was present at the time of the non-index colonoscopy to sedate the patient for the procedure?  1. Yes  2. No | 1,2 | The intent of this question is to determine if the patient was sedated for the procedure under the supervision of an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). This type of procedural sedation may be documented as Monitored Anesthesia Care (MAC).  Look at the colonoscopy report and any peri-procedural notes (including sedation records) available in the medical record for documentation of procedural sedation.  **Note:** may see the terms “anesthesia,” “anesthesiologist,” “CRNA (Certified Registered Nurse Anesthetist)”, “Propofol” (under medications), “See anesthesia note,” or “MAC (monitored anesthesia care).”  If any of the above terms are documented, select “Yes.”  If none of these terms are present, select “No.” |
| 39 | nonindx1 | Is there documentation of a specific reason (indication) the non-index colonoscopy was performed?  1. Yes  2. No | 1,2  If 2, auto-fill crcscrn3 as 95, nonrsk as 95, nindscr as 95, and go to nordind | **Only Acceptable Source:** **Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason (indication) may be used (e.g., pre-operative diagnosis).  Reasons ( indication) for performing a colonoscopy may include, but are not limited to:   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS * Symptoms such as bleeding, change in bowel habits, abdominal pain * Screening only |
| 40 | crcscrn3 | Is there physician/APN/PA documentation the non-index colonoscopy was performed for average-risk (routine) screening only?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nonindx1 = 2  If 1, go to nordind | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  In order to answer “1”, the physician/APN/PA documentation must clearly indicate the colonoscopy was performed for average-risk screening only.  It is not necessary to see the term “average-risk”.  If documentation indicates the colonoscopy was performed for routine screening, select “1”.  If documentation indicates the colonoscopy was performed due to symptoms such as bleeding, change in bowel habits, abdominal pain or any of the high-risk screening/surveillance indications listed below, enter “2”.  **High Risk Screening/Surveillance Indications:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS   **If the indication documented in the colonoscopy report/procedure note is conflicting (i.e., average-risk screening and rectal bleeding), enter “2”.** |
| 41 | nonrsk1  nonrsk2  nonrsk3  nonrsk4  nonrsk5  nonrsk6  nonrsk7  nonrsk95  nonrsk99 | Select all high-risk screening or surveillance indications documented in the non-index colonoscopy report/procedure note.  **Indicate all that apply:**  1. Family history of colorectal cancer  2. Family history of colorectal adenomas or polyps  3. Personal history of polyps  4. Personal history of colorectal cancer  5. Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis  6. High risk, NOS  7. Surveillance, NOS  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if nonindx1 = 2 | **Only Acceptable Source:** **Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason may be used (e.g., pre-operative diagnosis).  High-risk screening or surveillance involves testing patients that previously had colorectal cancer or are at increased risk for colorectal cancer. |
| 42 | nindscn | Is there physician/APN/PA documentation the non-index colonoscopy performed for a non-screening diagnostic indication (bleeding, positive FOBT, anemia, diarrhea, constipation, abdominal pain, etc.)?  1. Yes  2. No  95. Not applicable | 1,2  Will be auto-filled as 95 if nonindx1 = 2   |  | | --- | | Hard edit: If nonrsk99 = -1 cannot = 2 | | **Only Acceptable Source:** **Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason may be used (e.g., pre-operative diagnosis).  **Non-screening diagnostic indication** = person has symptoms of a condition or disease  If any non-screening diagnostic indication is documented by the physician/APN/PA as the reason for performing the colonoscopy, answer “1”. |
| 43 | nanatext | Is there documentation of the anatomic extent reached during the non-index colonoscopy?  1. Yes  2. No | 1,2  If 2, auto-fill nanreach as 95, and go to nqualprep | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Anatomic extent reached may be documented under a heading (e.g., **Extent of Examination:** Cecum) or in body of procedure report/note. For example:  **Description of Procedure and Findings:** Informed consent was obtained. Rectal examination by finger was unremarkable. **The scope was introduced all the way up to the cecum without any difficulty.** |
| 44 | nanreach | Is there documentation the cecum, appendix, appendiceal orifice, ileum, or small bowel was reached during the non-index colonoscopy?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nanatext = 2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  If there is documentation that the cecum, appendix, appendiceal orifice, ileum, or small bowel was reached during the colonoscopy, answer “1”. |
| 45 | nqualprep | Is there documentation of the quality of bowel preparation on the non-index colonoscopy?  1. Yes  2. No | 1,2  If 2, auto-fill npoorprep as 95, nprep as 95, and go to nbbpsprep | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Quality of preparation may be documented under a heading or in the body of the procedure report/note.  In order to answer “yes”, the header or statement must clearly refer to the overall quality of the bowel preparation. Disregard statements about visual quality as the scope is advanced through different sections of the colon that occur in the body rather than header of the report (i.e., are descriptors of the endoscopy rather than a summary assessment of overall preparation quality). **Examples include but are not limited to:**  “Parts of the transverse colon were obscured by stool” or “The cecum was adequate after extensive cleaning.”  However, the endoscopist may write an overall prep assessment such as “The quality of the preparation was excellent except the cecum was poor” which is acceptable.  **Exclude:** Documentation of Boston Bowel Prep Scale |
| 46 | npoorprep | Is there any mention of the bowel preparation being suboptimal, poor, or inadequate on the non-index colonoscopy?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nqualprep = 2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  If there is any mention that the quality of bowel preparation was suboptimal, poor, or inadequate, answer “1”. If quality of bowel prep is described as satisfactory (or other similar term), answer “2”. |
| 47 | nprep1  nprep2  nprep3  nprep4  nprep5  nprep95  nprep99 | Indicate the quality of bowel preparation documented in the procedure report/note.  **Indicate all that apply:**  1. Adequate (or satisfactory)  2. Good (or excellent)  3. Fair  4. Inadequate (or unsatisfactory)  5. Suboptimal (or poor)  95. Not applicable  99. None of the above or unable to determine | 1,2,3,4,5,95,99  Will be auto-filled as 95 if nqualprep = 2  Cannot enter 99 with any other number  Cannot enter 1 or 2 with 3, 4, or 5 | Select the value(s) that indicate the quality of bowel preparation documented in the procedure report/note. If the term used to describe the quality of bowel preparation is not listed or is not similar to one of the terms listed, select “99”.  If bowel prep quality documentation is conflicting (e.g. adequate except cecum was poor), select “99”. |
| 48 | nbbpsprep | Was the Boston Bowel Preparation Scale (BBPS) used to document the quality of bowel preparation?   1. Yes   No | 1,2  If 2, go to nonbiop | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  The BBPS requires a score be assigned to each segment (right (cecum and ascending), transverse, left (descending, sigmoid and rectum)) of the colon. The segment scores range from 0 – 3 and are summed for a total BBPS score ranging from 0 -9. Segment points are assigned by the endoscopist as follows:  0 = unprepared colon segment with mucosa note seen due to solid stool that cannot be cleared  1 = Portion of mucosa of the colon segment seen, but other areas of the colon segment not well seen due to staining, residual stool and/or opaque liquid.  2 = Minor amount of residual staining, small fragments of stool and/or opaque liquid, but mucosa of colon segment seen well.  3 = Entire mucosa of colon segment seen well with no residual staining, small fragments of stool or opaque liquid.  **If there is documentation the BBPS was used to document the quality of bowel preparation, select “1”.** |
| 49 | nbbpsr  nbbpst  nbbpsd | Enter the BBPS score for each colon segment documented in the colonoscopy report/procedure note.   |  |  | | --- | --- | | **Segment** | **Score**  Whole numbers  0 – 3  Abstractor may enter zz | | 1. Right colon (ascending) |  | | 1. Transverse colon |  | | 1. Left colon (descending) |  | | | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  **Enter the BBPS score for each colon segment documented in the colonoscopy report/procedure note.**  If the score for a colon segment is not documented enter zz. |
| 50 | nbbpstot | Enter the total BBPS score documented in the colonoscopy report/procedure note. | Whole numbers  0 -9  May enter zz | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Enter the BBPS total score documented in the colonoscopy report/procedure note.  If the total BBPS score is not documented in the colonoscopy report/procedure note, enter zz. |
| 51 | nonbiop | Was a biopsy or other tissue removal (e.g., polypectomy) performed during the non-index colonoscopy?  1. Yes  2. No | 1,2  If 2, auto-fill nbiop as 95,and go to nordind | Review the colonoscopy procedure note/report to determine if a biopsy or polyp was removed during the procedure.  Suggested data source: Colonoscopy report, Colonoscopy procedure note |
| 52 | nbiop1  nbiop2  nbiop3  nbiop95  nbiop99 | Do pathology results from biopsy/tissue removal show any of the following?  **Indicate all that apply:**   1. Adenoma or adenomatous polyp of the colon or rectum 2. Cancer, carcinoma, or adenocarcinoma of the colon or rectum 3. Inflammatory bowel disease (IBD, ulcerative colitis, or Crohn’s disease)   95. Not applicable  99. None of the above | 1,2,3,95,99  Will be auto-filled as 95 if nonbiop = 2 | Suggested data source: Pathology report |
| 53 | nordind | Is there physician/APN/PA documentation in the record of a specific reason (indication) the non-index colonoscopy was ordered?  1. Yes  2. No | 1,2  If 2, auto-fill crcscrn4 as 95, nordrsk as 95, nordiag as 95, and go to nonindt2 as applicable | If the reason or indication for the non-index colonoscopy was not documented by the physician performing the procedure, look for documentation of the reason the colonoscopy was ordered in the progress notes (or consult request) of the physician/APN/PA that referred the patient for the colonoscopy.  Reasons ( indication) for performing a colonoscopy may include, but are not limited to:   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS * Symptoms such as bleeding, change in bowel habits, abdominal pain * Screening only |
| 54 | crcscrn4 | Is there physician/APN/PA documentation the non-index colonoscopy was ordered for average-risk (routine) screening only?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nordind = 2  If 1, go to nonindt2 as applicable | In order to answer “1”, the physician/APN/PA that referred the patient for the colonoscopy must clearly indicate the colonoscopy was ordered for average-risk screening only. It is not necessary to see the term “average-risk”.  If documentation indicates the colonoscopy was ordered for routine screening, select “1”.  If documentation indicates the colonoscopy was ordered due to symptoms such as bleeding, change in bowel habits, abdominal pain or any of the high-risk screening/surveillance indications listed below, enter “2”.  High Risk Screening/Surveillance Indications:   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS |
| 55 | nordrsk1  nordrsk2  nordrsk3  nordrsk4  nordrsk5  nordrsk6  nordrsk7  nordrsk95  nordrsk99 | Select all high-risk screening or surveillance indications documented by the ordering physician/APN/PA.  Indicate all that apply:  1. Family history of colorectal cancer  2. Family history of colorectal adenomas or polyps  3. Personal history of polyps  4. Personal history of colorectal cancer  5. Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis  6. High risk, NOS  7. Surveillance, NOS  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if nordind = 2 | High-risk screening or surveillance involves testing patients that previously had colorectal cancer or are at increased risk for colorectal cancer. |
| 56 | nordiag | Was the non-index colonoscopy ordered for a non-screening diagnostic indication (bleeding, anemia, positive FOBT, diarrhea, constipation, abdominal pain, etc.)?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nordind = 2   |  | | --- | | Hard edit: If nordrsk99 = -1 cannot = 2 | | Non-screening diagnostic indication = person has symptoms of a condition or disease  If any non-screening diagnostic indication is documented by the physician/APN/PA as the reason for ordering the colonoscopy, answer “1”. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Other Non-Index Colonoscopy** |  |  |
| 57 | nonindt2 | Enter the date of the most recent non-index colonoscopy performed prior to the most recent non-index colonoscopy. | mm/dd/yyyy  **Computer will pre-fill date of non-index colonoscopy prior to most recent non-index colonoscopy**  **If null and nbiop = 99, go to othpath1; else if null, go to colfobt**   |  | | --- | | <= 10 years prior to indexdt and < nonindt1 | | Computer will pre-fill the date of the most recent non-index colonoscopy performed within 10 years prior to the most recent non-index colonoscopy. |
| 58 | nonindx2 | On (computer to display nonindt2), is there documentation that the non-index colonoscopy was completed?  1. Yes  2. No | 1,2  If 1, auto-fill othnon2 as 95, actnondt2 as 99/99/9999, and go to pcolnva5 | Search procedure reports, surgical reports, and progress notes for documentation that a non-index colonoscopy was performed on date entered in NONINDT2. |
| 59 | othnon2 | During the timeframe from (computer to display nonindt2 – 180 days to nonindt2 + 180 days), is there documentation a non-index colonoscopy was performed?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nonindx2 = 1  **\*If 2 and nbiop = 99, go to othpath1; else, go to colfobt** | Search procedure reports, surgical reports, and progress notes for documentation that a non-index colonoscopy was performed within 180 days prior to or after the pre-filled non-index colonoscopy date. |
| 60 | actnondt2 | Enter the date of the non-index colonoscopy performed during the (computer to display computer to display nonindt2 – 180 days to nonindt2 + 180 days). | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if nonindx2 = 1   |  | | --- | | <= 180 days prior to or after nonindt2 | | If more than one non-index colonoscopy was performed within 180 days prior to or after the non-index colonoscopy date, enter the date of the other colonoscopy performed closest to the date of the non-index colonoscopy. |
| 61 | pcolnva5 | Was the non-index colonoscopy performed at a VAMC?  1. Yes  2. No | 1,\*2  \*If 2 and nbiop = 99, go to othpath1; else if 2, go to colfobt | If the non-index colonoscopy was performed at a VAMC, enter “1”.  If the non-index colonoscopy was performed outside the VHA, enter “2”. |
| 62 | colnrpt3 | Was the non-index colonoscopy procedure report/note found in the medical record?  3. Procedure report found in CPRS  4. Procedure report found in VISTA imaging  99. Procedure report not found in medical record | 3,4,99  **Warning if 99 and pcolnva5 = 1**  **If 99 and nbiop = 99, go to othpath1, else if 99, go to colfobt** | If the actual non-index colonoscopy procedure report/note is not found in CPRS or VISTA imaging, enter “99”.  Suggested data sources: Notes, consults, procedures, VISTA imaging |
| 63 | anescoln3 | Is there documentation that an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) was present at the time of the non-index colonoscopy to sedate the patient for the procedure?  1. Yes  2. No | 1,2 | **The intent of this question is to determine if the patient was sedated for the procedure under the supervision of an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA).** This type of procedural sedation may be documented as Monitored Anesthesia Care (MAC).  Look at the colonoscopy report and any peri-procedural notes (including sedation records) available in the medical record for documentation of procedural sedation.  Note: may see the terms “anesthesia,” “anesthesiologist,” “CRNA (Certified Registered Nurse Anesthetist)”, “Propofol” (under medications), “See anesthesia note,” or “MAC (monitored anesthesia care).”  If any of the above terms are documented, select “Yes.”  If none of these terms are present, select “No.” |
| 64 | nonind2 | Is there documentation of a specific reason (indication) the non-index colonoscopy was performed?  1. Yes  2. No | 1,2  If 2, auto-fill crcscrn5 as 95, sothrsk as 95, and go to nordind2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason (indication) may be used (e.g., pre-operative diagnosis).  Reasons ( indication) for performing a colonoscopy may include, but are not limited to:   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS * Symptoms such as bleeding, change in bowel habits, abdominal pain * Screening only |
| 65 | crcscrn5 | Is there physician/APN/PA documentation the non-index colonoscopy was performed for average-risk (routine) screening only?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nonind2 = 2  If 1, go to nordind2 | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  In order to answer “1”, the physician/APN/PA documentation must clearly indicate the colonoscopy was performed for average-risk screening only.  It is not necessary to see the term “average-risk”.  If documentation indicates the colonoscopy was performed for routine screening, select “1”.  If documentation indicates the colonoscopy was performed due to symptoms such as bleeding, change in bowel habits, abdominal pain or any of the high-risk screening/surveillance indications listed below, enter “2”.  **High Risk Screening/Surveillance Indications:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS |
| 66 | sothrsk1  sothrsk2  sothrsk3  sothrsk4  sothrsk5  sothrsk6  sothrsk7  sothrsk95  sothrsk99 | Select all high-risk screening or surveillance indications documented in the non-index colonoscopy report/procedure note.  **Indicate all that apply:**  1. Family history of colorectal cancer  2. Family history of colorectal adenomas or polyps  3. Personal history of polyps  4. Personal history of colorectal cancer  5. Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis  6. High risk, NOS  7. Surveillance, NOS  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if nonind2 = 2   |  | | --- | | Warning if 99 and nonind2 = 1 | | **Only Acceptable Source: Colonoscopy Report or Colonoscopy Procedure Note**  Other terms for reason (indication) may be used (e.g., pre-operative diagnosis).  High-risk screening or surveillance involves testing patients that previously had colorectal cancer or are at increased risk for colorectal cancer. |
| 67 | nordind2 | Is there physician/APN/PA documentation in the record of a specific reason (indication) the non-index colonoscopy was ordered?  1. Yes  2. No | 1,2  If 2, auto-fill crcscrn6 as 95, sordrsk as 95, AND if nbiop = 99, go to othpath1; else, if 2, go to colfobt | If the reason or indication for the non-index colonoscopy was not documented by the physician performing the procedure, look for documentation of the reason the colonoscopy was ordered in the progress notes (or consult request) of the physician/APN/PA that referred the patient for the colonoscopy.  **Reasons ( indication) for performing a colonoscopy may include, but are not limited to:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS * Symptoms such as bleeding, change in bowel habits, abdominal pain * Screening only |
| 68 | crcscrn6 | Is there physician/APN/PA documentation the non-index colonoscopy was ordered for average-risk (routine) screening only?  1. Yes  2. No  95. Not applicable | 1,2,95  Will be auto-filled as 95 if nordind2 = 2  If 1, go to nonbiop2 | In order to answer “1”, the physician/APN/PA that referred the patient for colonoscopy must clearly indicate the colonoscopy was ordered for average-risk screening only.  It is not necessary to see the term “average-risk”.  If documentation indicates the colonoscopy was ordered for routine screening, select “1”.  If documentation indicates the colonoscopy was ordered due to symptoms such as bleeding, change in bowel habits, abdominal pain or any of the high-risk screening/surveillance indications listed below, enter “2”.  **High Risk Screening/Surveillance Indications:**   * Family history of colorectal cancer * Family history of colorectal adenomas or polyps * Personal history of polyps * Personal history of colorectal cancer * Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis * High risk, NOS * Surveillance, NOS |
| 69 | sordrsk1  sordrsk2  sordrsk3  sordrsk4  sordrsk5  sordrsk6  sordrsk7  sordrsk95  sordrsk99 | Select all high-risk screening or surveillance indications documented by the ordering physician/APN/PA.  **Indicate all that apply:**  1. Family history of colorectal cancer  2. Family history of colorectal adenomas or polyps  3. Personal history of polyps  4. Personal history of colorectal cancer  5. Inflammatory bowel disease, Crohn’s disease, or ulcerative colitis  6. High risk, NOS  7. Surveillance, NOS  95. Not applicable  99. None of the above | 1,2,3,4,5,6,7,95,99  Will be auto-filled as 95 if nordind2 = 2 | High-risk screening or surveillance involves testing patients that previously had colorectal cancer or are at increased risk for colorectal cancer. |
| 70 | nonbiop2 | Was a biopsy or other tissue removal (e.g., polypectomy) performed during the non-index colonoscopy?  1. Yes  2. No | 1,2  If 2, auto-fill sbiop as 95 and go to othpath1 | Review the colonoscopy procedure note/report to determine if a biopsy or polyp was removed during the procedure.  Suggested data source: Colonoscopy report, Colonoscopy procedure note |
| 71 | sbiop1  sbiop2  sbiop3  sbiop95  sbiop99 | Do pathology results from biopsy/tissue removal show any of the following?  **Indicate all that apply:**  **1.** Adenoma or adenomatous polyp of the colon or rectum  **2.** Cancer, carcinoma, or adenocarcinoma of the colon or rectum  **3.** Inflammatory bowel disease (IBD, ulcerative colitis, or Crohn’s disease)  95. Not applicable  99. None of the above | 1,2,3,95,99  Will be auto-filled as 95 if nonbiop2 = 2  If 1,2,or 3, auto-fill othpath as 95, and go to colfobt | Suggested data source: Pathology report |
| 72 | othpath1  othpath2  othpath3  othpath95  othpath99 | During the timeframe from (computer to display indexdt - 10 years to indexdt – 1 day), does VHA anatomic/surgical pathology data document a history of any of the following high-risk features?  **Indicate all that apply:**  **1.** Adenoma or adenomatous polyp of the colon or rectum  **2.** Cancer, carcinoma, or adenocarcinoma of the colon or rectum  **3.**Inflammatory bowel disease (IBD, ulcerative colitis, or Crohn’s disease)  95. Not applicable  99. None of the above | 1,2,3,95,99  Will be auto-filled as 95 if sbiop = 1,2, or 3  If 99, auto-fill othpathdt as 99/99/9999 | Search anatomic/surgical pathology data for any reports on colon/rectal specimens during the 10 years prior to the index colonoscopy.  **DO NOT INCLUDE PATHOLOGY RESULTS FROM THE INDEX COLONOSCOPY.** |
| 73 | othpathdt | Enter the date of the earliest report documenting high-risk colon/rectal pathology features. | mm/dd/yyyy  Will be auto-filled as 99/99/9999 if othpath = 99   |  | | --- | | <= 10 years prior to indexdt and < indexdt | | If more than one anatomic/surgical pathology report documents high-risk colon/rectal pathology features, enter the date of the earliest report.  Enter the exact date. |
|  |  | **Fecal Occult Blood Testing** |  |  |
| 74 | colfobt | Does the medical record contain the result(s) of any fecal occult blood testing done during the timeframe from (computer to display indexdt – 12 months to indexdt – 1 day)?  3. FOBT done in VHA  4. FOBT done in private sector  99**.** No result of FOBT done within the past 12 months | 3,4,\*99  **\*If 99, go to end** | The FOBT result(s) must be documented in the medical record during the 12 months prior to the index colonoscopy. Patient self-report of FOBT is NOT acceptable.  Suggested data sources: Lab reports, VISTA imaging |
| 75 | cfobtdt | Enter the date of the of the most recent FOBT result(s) reported. | mm/dd/yyyy   |  | | --- | | <= 12 months prior to indexdt and < indexdt | | Enter the exact date. |
| 76 | fobtype | What type of FOBT was performed?  1. Guaiac (gFOBT)  2. Immunochemical (iFOBT/FIT)  99. Unable to determine | 1,2,99 | If unable to determine whether the fecal occult blood testing was guaiac (gFOBT) or immunochemical (iFOBT), select “99”. |
| 77 | ifobtnum | Enter the number of FOBT results reported in the record on (computer to display cfobtdt). | \_\_\_\_   |  | | --- | | Whole numbers  1 - 3 | | Enter the exact number of FOBT results reported on the date entered in CFOBTDT. |
| 78 | cfobtpos | Was at least one result of the most recent FOBT (or set of screening FOBTs) reported as positive?  1. Yes  2. No | 1,2 | If at least one FOBT test result was reported as positive, select “1”. If all reported results were negative, select “2”. |