
**Ontario Familial Colon Cancer Registry Treatment and Outcome Study
CLINICAL DIAGNOSIS AND TREATMENT FORM**

OFCCR # _____
 OCGN # _____
 OCR Group # _____

Name: _____ / _____
 LAST **FIRST**

Sex:

<input type="checkbox"/>	Male
<input type="checkbox"/>	Female
<input type="checkbox"/>	Unknown

Date of Birth:

DD	
MM	
YYYY	

CLINICAL DIAGNOSIS AND TREATMENT - BASELINE

1. Place of Diagnosis:

Name	City or Town	MOH Code

2. Site of Cancer(s):

Cancer	Site Name	4-Digit ICD-9 Code
1.		
2.		
3.		
4.		
5.		

3. Date of initial diagnosis of colorectal cancer (please use histological date i.e. Date of pathology report):

DD	
MM	
YYYY	
<input type="checkbox"/>	Unknown

4. Preoperative symptoms (please check all that apply):

<input type="checkbox"/>	None, asymptomatic (detected by screening)
<input type="checkbox"/>	Bleeding
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Pain
<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

5. Method of colorectal cancer diagnosis:

<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Rigid sigmoidoscopy
<input type="checkbox"/>	Flexible sigmoidoscopy
<input type="checkbox"/>	Sigmoidoscopy NOS
<input type="checkbox"/>	Barium enema
<input type="checkbox"/>	Chest x-ray
<input type="checkbox"/>	Chest CT scan
<input type="checkbox"/>	Abdominal/Pelvic CT scan
<input type="checkbox"/>	Ultrasound
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

6. Type of definitive surgery for colorectal cancer (SEER coding used) (please attach all pathology and operative reports for this colorectal cancer):

<input type="checkbox"/>	None
<input type="checkbox"/>	Local tumour destruction, i.e. laser, electrocautery
<input type="checkbox"/>	Local surgical excision with specimen i.e. polypectomy, snare
<input type="checkbox"/>	Segmental resection, not hemi-colectomy i.e. cecectomy, appendectomy, sigmoidectomy, partial resection of transverse colon and flexures, iliocollectomy, enterocollectomy, partial colectomy, NOS <input type="checkbox"/> Low Anterior
<input type="checkbox"/>	Hemi-colectomy, but not total. Right or left, must include a portion of transverse colon
<input type="checkbox"/>	Abdominoperineal resection
<input type="checkbox"/>	Total or subtotal colectomy, not rectum
<input type="checkbox"/>	Colectomy NOS
<input type="checkbox"/>	Segmental colectomy + other organs (*Please specify below)
<input type="checkbox"/>	Hemi-colectomy + other organs (*Please specify below)
<input type="checkbox"/>	Total or subtotal colectomy or + other organs (*Please specify below)
<input type="checkbox"/>	Abdominoperineal resection + other organs (*Please specify below)
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

*If Other Organs were removed:

<input type="checkbox"/>	Spleen
<input type="checkbox"/>	Gallbladder
<input type="checkbox"/>	Appendix (not a part of colon resection)
<input type="checkbox"/>	Stomach
<input type="checkbox"/>	Pancreas
<input type="checkbox"/>	Small intestine
<input type="checkbox"/>	Liver
<input type="checkbox"/>	Abdominal Wall, Retroperitoneum
<input type="checkbox"/>	Adrenal
<input type="checkbox"/>	Kidney
<input type="checkbox"/>	Bladder
<input type="checkbox"/>	Urethra
<input type="checkbox"/>	Ovary
<input type="checkbox"/>	Uterus
<input type="checkbox"/>	Vagina
<input type="checkbox"/>	Prostate
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

7. If no surgery was performed, reason:

<input type="checkbox"/>	Patient Refusal
<input type="checkbox"/>	Antecedent Death
<input type="checkbox"/>	Medical Contraindication
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

8. Summary of disease from pathology report only:

pT	
pN	
pM	
<input type="checkbox"/>	Unknown

9. If pN1 or greater (if pN0 pls. go to #14):

Number of Nodes Reported	
Number of Nodes Positive	

10. Pathological Stage of disease (from all information available):

T	
N	
M	
<input type="checkbox"/>	Unknown

11. Stage of disease at initial diagnosis (from all information available)

<input type="checkbox"/>	Stage 0
<input type="checkbox"/>	Stage 1
<input type="checkbox"/>	Stage 2
<input type="checkbox"/>	Stage 3
<input type="checkbox"/>	Stage 4
<input type="checkbox"/>	Unknown

12. Other Pathology Identified:

Yes	Type:	No	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Diverticulosis/it is <input type="checkbox"/> Perforation <input type="checkbox"/> Other Please Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

13. Preoperative CEA (carcinoembryonic antigen):

<input type="checkbox"/>	Yes _____ ug/L
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

14. Date of Blood Test for Preoperative CEA:

DD	
MM	
YYYY	
<input type="checkbox"/>	Unknown

15. Date of surgery:

DD	
MM	
YYYY	
<input type="checkbox"/>	Unknown

16. Primary surgery hospital:

Name	City or Town	MOH Code

17. Operating Surgeon:

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18. Operative findings, local (residual tumour) (please obtain information from the operative report and/or the discharge summary)

<input type="checkbox"/>	Tumour <i>not entirely</i> resected
<input type="checkbox"/>	Tumour <i>entirely</i> resected
<input type="checkbox"/>	Unknown

19. Operative findings, Distant (pls. obtain info. from the operative report &/or the discharge summary):

No Metastatic Disease	Metastatic Disease Found	Type of Metastatic Disease Found:	Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ascites <input type="checkbox"/> Mesenteric nodes, other than in mesentery of planned resection <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Omentum <input type="checkbox"/> Abdominal wall <input type="checkbox"/> Ovaries <input type="checkbox"/> Bone <input type="checkbox"/> Peritoneum <input type="checkbox"/> Mesentery <input type="checkbox"/> Other Please Specify: _____	<input type="checkbox"/>

20. Margins:

Negative	Positive	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Proximal <input type="checkbox"/> Distal <input type="checkbox"/> Radial <input type="checkbox"/> Other Please Specify: _____	<input type="checkbox"/>

(CONCURRENT) PRIMARY DIAGNOSIS # _____ Please see Ques.#2 to identify Site #.
(Please complete a separate form for each primary diagnosis).

21. Grade of Primary:

Well Differentiated	Moderately Differentiated	Poorly Differentiated	Undifferentiated	Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. Cell Type:

<input type="checkbox"/>	Adenoca.
<input type="checkbox"/>	NOS
<input type="checkbox"/>	Mucinous
<input type="checkbox"/>	Signet ring cell
<input type="checkbox"/>	Other Please specify: _____
<input type="checkbox"/>	Unknown

23. Vascular Invasion:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

24. Lymphatic Invasion:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

25. Perineural Invasion:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

26. Patient Enrolled in a clinical trial:

<input type="checkbox"/>	Yes Please Specify: _____
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

27. Oncologist(s): Not assessed

1.	3.
2.	4.

28. Chemotherapy given (If yes, pls. complete Treatment table below & attach all flow sheets):

Yes	Type	No (Pls. go to #32)	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

Height	Weight	B.S.A.
_____.____ cm <input type="checkbox"/> Unknown	_____.____ kg <input type="checkbox"/> Unknown	____.____ m2 <input type="checkbox"/> Unknown

CHEMOTHERAPY TREATMENT (For cyclic chemo., pls. report each cycle *separately* e.g. 1, 2, 3, 4)
FOR BASELINE DIAGNOSIS

First Course Only.

Flow sheet attached Y/N: _____

Cycle #	Name	Drug Dosage	IV/PO	Days Given	Date Given	Palliative Therapy Response
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

32. Radiation given (*please attach all flow sheets, where available*):

Yes	Type	No	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

CLINICAL FOLLOW-UP SINCE BASELINE DIAGNOSIS

33. **New** cancer event in the four years following the initial diagnosis:

Yes	Check off as many that apply and complete the corresponding section.	None	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Locoregional Recurrence <input type="checkbox"/> Distant Recurrence <input type="checkbox"/> Other Non-Colorectal Primary <input type="checkbox"/> Colorectal Primary <input type="checkbox"/> Death	<input type="checkbox"/>	<input type="checkbox"/>

34. Patient Enrolled in a clinical trial since baseline:

<input type="checkbox"/>	Yes Please Specify: _____
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

FIRST LOCOREGIONAL RECURRENCE

None (go to #43)

If applicable, please attach copies of documentation (i.e. radiology reports, clinic notes, pathology reports, operative reports, etc.) with the date of first detection of site(s) of first locoregional recurrence(s).

35. Sites of involvement at time of first locoregional recurrence (*please check off all that apply*):

	Site	First Diagnosed Day	First Diagnosed Month	First Diagnosed Year
<input type="checkbox"/>	Anastomosis			
<input type="checkbox"/>	Mesentery			
<input type="checkbox"/>	Abdominal Wall (not incisional)			
<input type="checkbox"/>	Incisional			
<input type="checkbox"/>	Pelvis			
<input type="checkbox"/>	Other Please specify: _____			
<input type="checkbox"/>	Unknown			

36. Surgery for locoregional recurrence:

<input type="checkbox"/>	Yes Please specify: _____
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

37. Treatment for locoregional recurrence:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

38. Oncologist(s): Not assessed

1.	3.
2.	4.

39. Chemotherapy given (If yes, pls. complete Treatment table below & attach all flow sheets):

Yes	Type	No (Pls. go to #A6)	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

Height	Weight	B.S.A.
____.____ cm	____.____ kg	____.____ m ²
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

CHEMOTHERAPY TREATMENT (For cyclic chemo., pls. report each cycle *separately* e.g. 1, 2, 3, 4)
FOR FIRST LOCOREGIONAL RECURRENCE

First Course.

Flow sheet attached Y/N: _____

Cycle #	Name	Drug Dosage	IV/PO	Days Given	Date Given	Palliative Therapy Response
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

40. Radiation given (*please attach all flow sheets, where available*):

Yes	Type	No	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

41. Other treatment given (*please attach all documents*):

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

42. Other Locoregional recurrence sites after the first site was identified (*please check off all that apply*):

	Site	Diagnosed Day	Diagnosed Month	Diagnosed Year
<input type="checkbox"/>	Anastomosis			
<input type="checkbox"/>	Mesentery			
<input type="checkbox"/>	Abdominal Wall (not incisional)			
<input type="checkbox"/>	Incisional			
<input type="checkbox"/>	Pelvis			
<input type="checkbox"/>	Other Please specify: _____ _____			
<input type="checkbox"/>	Unknown			

FIRST DISTANT RECURRENCE

None (go to #51)

If applicable, please attach copies of documentation (i.e. radiology reports, clinic notes, pathology reports, operative reports, etc.) with the date of first detection of site(s) of first distant recurrence(s).

43. Sites of involvement at time of first distant recurrence (*please check off all that apply*):

	Site	First Diagnosed Day	First Diagnosed Month	First Diagnosed Year
<input type="checkbox"/>	Liver			
<input type="checkbox"/>	Lung			
<input type="checkbox"/>	Bone			
<input type="checkbox"/>	Ascites			
<input type="checkbox"/>	Non-mesenteric lymph nodes (except supraclavicular) Please specify: _____ _____			
<input type="checkbox"/>	Supraclavicular nodes			
<input type="checkbox"/>	Brain			
<input type="checkbox"/>	Skin, except incision Please specify: _____			
<input type="checkbox"/>	Adrenal gland			
<input type="checkbox"/>	Other Please specify: _____			

44. Surgery for distant recurrence:

<input type="checkbox"/>	Yes Please specify: _____
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

45. Treatment for distant recurrence:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

46. Oncologist(s): Not assessed

1.	3.
2.	4.

47. Chemotherapy given (If yes, pls. complete Treatment table below & attach all flow sheets):

Yes	Type	No (Pls. go to #B6)	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

Height	Weight	B.S.A.
_____ cm <input type="checkbox"/> Unknown	_____ kg <input type="checkbox"/> Unknown	_____ m ² <input type="checkbox"/> Unknown

CHEMOTHERAPY TREATMENT (For cyclic chemo., pls. report each cycle *separately* e.g. 1, 2, 3, 4)
FOR FIRST DISTANT RECURRENCE

First Course.

Flow sheet attached Y/N: _____

Cycle #	Name	Drug Dosage	IV/PO	Days Given	Date Given	Palliative Therapy Response
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

						<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
						<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
						<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

48. Radiation given (*please attach all flow sheets, where available*):

Yes	Type	No	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

49. Other treatment given (*please attach all documents*):

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

50. Other Distant recurrence sites after the first site was identified (*please check off all that apply*):

	Site	Diagnosed Day	Diagnosed Month	Diagnosed Year
<input type="checkbox"/>	Liver			
<input type="checkbox"/>	Lung			
<input type="checkbox"/>	Bone			
<input type="checkbox"/>	Ascites			
<input type="checkbox"/>	Non-mesenteric lymph nodes (except supraclavicular) Please specify: _____			
<input type="checkbox"/>	Supraclavicular nodes			
<input type="checkbox"/>	Brain			
<input type="checkbox"/>	Skin, except incision Please specify: _____			
<input type="checkbox"/>	Adrenal gland			
<input type="checkbox"/>	Other Please specify: _____			

OTHER NON-COLORECTAL PRIMARY(S)

None (go to #55)

51. Hospital of Diagnosis:

Name	City or Town	MOH Code

52. Sites of new Non-Colorectal Primary Cancer(s) since the initial diagnosis of Colorectal cancer:

Cancer	Site	4-Digit ICD-9 Code
1.		
2.		
3.		
4.		
5.		

53. Date(s) of diagnosis of new Non-Colorectal Primary Cancer(s) (please use histological date):

Cancer	Day	Month	Year
1.			
2.			
3.			
4.			
5.			

54. Stage(s) of new Non-Colorectal Primary Cancer(s):

Cancer	Stage 0	Stage 1	Stage 2	Stage 3	Stage 4	Unknown
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NEW COLORECTAL PRIMARY(S)

None (go to #80)

55. Site of Cancer(s):

Cancer	Site Name	4-Digit ICD-9 Code	Diag. Day	Diag. Month	Diag. Year	Unknown
1.						<input type="checkbox"/>
2.						<input type="checkbox"/>
3.						<input type="checkbox"/>
4.						<input type="checkbox"/>
5.						<input type="checkbox"/>

56. Preoperative symptoms (please check all that apply):

<input type="checkbox"/>	None, asymptomatic (detected by screening)
<input type="checkbox"/>	Bleeding
<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Pain
<input type="checkbox"/>	Weight Loss
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

57. Method of colorectal cancer diagnosis (check all that apply):

<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Rigid sigmoidoscopy
<input type="checkbox"/>	Flexible sigmoidoscopy
<input type="checkbox"/>	Sigmoidoscopy NOS
<input type="checkbox"/>	Barium enema
<input type="checkbox"/>	Chest x-ray
<input type="checkbox"/>	Chest CT scan
<input type="checkbox"/>	Abdominal CT scan
<input type="checkbox"/>	Ultrasound
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

58. Type of definitive surgery for colorectal cancer (SEER coding used) (please attach all pathology and operative reports for this colorectal cancer):

<input type="checkbox"/>	None (please go to #18)
<input type="checkbox"/>	Local tumour destruction, i.e. laser, electrocautery
<input type="checkbox"/>	Local surgical excision with specimen i.e. polypectomy, snare
<input type="checkbox"/>	Segmental resection, not hemi-colectomy i.e. cecectomy, appendectomy, sigmoidectomy, partial resection of transverse colon and flexures, iliocollectomy, enterocollectomy, partial colectomy, NOS <input type="checkbox"/> Low Anterior
<input type="checkbox"/>	Hemi-colectomy, but not total. Right or left, must include a portion of transverse colon
<input type="checkbox"/>	Abdominoperineal resection
<input type="checkbox"/>	Total or subtotal colectomy, not rectum
<input type="checkbox"/>	Colectomy NOS
<input type="checkbox"/>	Segmental colectomy + other organs (*Please specify below)
<input type="checkbox"/>	Hemi-colectomy + other organs (*Please specify below)
<input type="checkbox"/>	Total or subtotal colectomy or + other organs (*Please specify below)
<input type="checkbox"/>	Abdominoperineal resection + other organs (*Please specify below)
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

*If Other Organs were removed:

<input type="checkbox"/>	Spleen
<input type="checkbox"/>	Gallbladder
<input type="checkbox"/>	Appendix (not a part of colon resection)
<input type="checkbox"/>	Stomach
<input type="checkbox"/>	Pancreas
<input type="checkbox"/>	Small intestine
<input type="checkbox"/>	Liver
<input type="checkbox"/>	Abdominal wall, Retroperitoneum
<input type="checkbox"/>	Adrenal
<input type="checkbox"/>	Kidney

<input type="checkbox"/>	Bladder
<input type="checkbox"/>	Urethra
<input type="checkbox"/>	Ovary
<input type="checkbox"/>	Uterus
<input type="checkbox"/>	Vagina
<input type="checkbox"/>	Prostate
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

59. If no surgery was performed, reason:

<input type="checkbox"/>	Patient Refusal
<input type="checkbox"/>	Antecedent Death
<input type="checkbox"/>	Medical Contraindication
<input type="checkbox"/>	Other Please Specify: _____
<input type="checkbox"/>	Unknown

60. Summary of disease from pathology report only:

pT	
pN	
pM	
<input type="checkbox"/>	Unknown

61. If pN1 or greater (if pN0 pls. go to #D8):

Number of Nodes Reported	
Number of Nodes Positive	

62. Pathological Stage of disease (from all information available):

T	
N	
M	
<input type="checkbox"/>	Unknown

63. Stage of disease at initial diagnosis (from all information available)

<input type="checkbox"/>	Stage 0
<input type="checkbox"/>	Stage 1
<input type="checkbox"/>	Stage 2
<input type="checkbox"/>	Stage 3
<input type="checkbox"/>	Stage 4
<input type="checkbox"/>	Unknown

64. Other Pathology Identified:

Yes	Type:	No	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Diverticulosis/it is <input type="checkbox"/> Perforation <input type="checkbox"/> Other Please Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

65. Preoperative CEA (carcinoembryonic antigen):

<input type="checkbox"/>	Yes _____ ug/L
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

66. Date of Blood Test for Preoperative CEA:

DD	
MM	
YYYY	
<input type="checkbox"/>	Unknown

67. Date of surgery:

DD	
MM	
YYYY	
<input type="checkbox"/>	Unknown

68. Primary surgery hospital:

Name	City or Town	MOH Code

69. Operating Surgeon:

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70. Operative findings, local (residual tumour) (please obtain information from the operative report and/or the discharge summary)

<input type="checkbox"/>	Tumour <i>not entirely</i> resected
<input type="checkbox"/>	Tumour <i>entirely</i> resected
<input type="checkbox"/>	Unknown

71. Operative findings, Distant (pls. obtain info. from the operative report &/or the discharge summary):

No Metastatic Disease	Metastatic Disease Found	Type of Metastatic Disease Found:	Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ascites <input type="checkbox"/> Mesenteric nodes, other than in mesentery of planned resection <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Omentum <input type="checkbox"/> Abdominal wall <input type="checkbox"/> Ovaries <input type="checkbox"/> Bone <input type="checkbox"/> Peritoneum <input type="checkbox"/> Mesentery <input type="checkbox"/> Other Please Specify: _____	<input type="checkbox"/>

72. Margins:

Negative	Positive	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Proximal <input type="checkbox"/> Distal <input type="checkbox"/> Radial <input type="checkbox"/> Other Please Specify: _____	<input type="checkbox"/>

(CONCURRENT) PRIMARY DIAGNOSIS # _____ Please see Ques.#5 to identify Site #.
(Please complete a separate form for each primary diagnosis).

73. Grade of Primary:

Well Differentiated	Moderately Differentiated	Poorly Differentiated	Undifferentiated	Unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

74. Cell Type:

<input type="checkbox"/>	Adenoca.
<input type="checkbox"/>	NOS
<input type="checkbox"/>	Mucinous
<input type="checkbox"/>	Signet ring cell
<input type="checkbox"/>	Other Please specify: _____
<input type="checkbox"/>	Unknown

75. Vascular Invasion:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

76. Lymphatic Invasion:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

77. Perineural Invasion:

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

78. Oncologist(s): Not assessed

1.	3.
2.	4.

79. Chemotherapy given (If yes, pls. complete Treatment table below & attach all flow sheets):

Yes	Type	No (Pls. go to #D28)	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

Height	Weight	B.S.A.
_____ cm	_____ kg	_____ m ²
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

CHEMOTHERAPY TREATMENT (For cyclic chemo., pls. report each cycle *separately* e.g. 1, 2, 3, 4)
FOR NEW CRC PRIMARY

First Course

Flow sheet attached Y/N:

Cycle #	Name	Drug Dosage	IV/PO	Days Given	Date Given	Palliative Therapy Response
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

						<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown
						<input type="checkbox"/> Progression <input type="checkbox"/> Stable <input type="checkbox"/> Minor <input type="checkbox"/> Partial <input type="checkbox"/> Complete <input type="checkbox"/> Unknown

79. Radiation given (*please attach all flow sheets, where available*):

Yes	Type	No	Unknown
<input type="checkbox"/>	<input type="checkbox"/> Adjuvant <input type="checkbox"/> Palliative	<input type="checkbox"/>	<input type="checkbox"/>

DEATH

80. Date of Death:

DD	
MM	
YYYY	

81. Cause of Death (*please attach copy of death certificate if available*):

<input type="checkbox"/>	Colorectal cancer
<input type="checkbox"/>	Other, No colorectal present Please specify: _____
<input type="checkbox"/>	Other, colorectal present Please specify: _____
<input type="checkbox"/>	Unknown

82. Autopsy performed (*please attach copy of report if available*):

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Unknown

83. Location of Death:

<input type="checkbox"/>	Hospital Please specify: _____
<input type="checkbox"/>	Home
<input type="checkbox"/>	Hospice Please specify: _____
<input type="checkbox"/>	Other Please specify: _____
<input type="checkbox"/>	Unknown

DATE OF FINAL CHART NOTE: _____

PATIENT HAS BEEN REFERRED TO THE CARE OF: DR. _____

ADDITIONAL FOLLOW-UP REQUIRED (Y/N): _____

Date form Completed: _____ (dd/mmm/yyyy)

Abstractor's Initials: _____

ADDITIONAL NOTES: