

<b>Facility ID Number</b>	(auto filled)
<b>Case Registration Date</b>	___/___/_____ (mm/dd/yyyy)
<b>1. Patient Information</b>	
Patient ID	(auto filled)
*Social Security Number or Other ID	SSN: _____ - _____ - _____ Or Other ID: _____ Description: _____ (e.g. SIN)
*First Name	_____
Middle Name	_____
*Last Name	_____
*Old Medicare Beneficiary ID (prior to April 2018)	_____
*New Medicare Beneficiary ID (April 2018 or later)	_____
*Date of Birth	___/___/_____ (mm/dd/yyyy)
*Patient Sex	Select one: <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other <input type="radio"/> Unknown
Race	Select one: <input type="radio"/> American Indian or Alaska Native <input type="radio"/> Asian <input type="radio"/> Black or African American <input type="radio"/> Unknown <input type="radio"/> Native Hawaiian or Pacific Islander <input type="radio"/> White <input type="radio"/> Other <input type="radio"/> Not Reported
Hispanic Origin	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Not Reported <input type="radio"/> Unknown
Health Insurance	Select all that apply: <input type="radio"/> Medicare <input type="radio"/> Medicaid <input type="radio"/> Private Insurance <input type="radio"/> Self Pay <input type="radio"/> VA <input type="radio"/> Unknown <input type="radio"/> Other, please specify: _____
Education Level	Select one: <input type="radio"/> 8 <sup>th</sup> Grade or less <input type="radio"/> 9 <sup>th</sup> -11 <sup>th</sup> Grade <input type="radio"/> High School Graduate or high school equivalency <input type="radio"/> Post high school training, other than college (vocational /technical school) <input type="radio"/> Associate degree/some college <input type="radio"/> Graduate or professional school <input type="radio"/> Bachelor's degree <input type="radio"/> Unknown/refused to answer <input type="radio"/> Other, please specify: _____
COVID Vaccine	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown
COVID Vaccine Date	___/___/_____ (mm/dd/yyyy)
COVID Vaccine Manufacturer	Select one: <input type="radio"/> Johnson & Johnson Janssen <input type="radio"/> Moderna <input type="radio"/> Novavax <input type="radio"/> Oxford-AstraZeneca <input type="radio"/> Pfizer-BioNTech <input type="radio"/> Unknown <input type="radio"/> Other, please specify: _____
COVID Vaccine Site	Select one: <input type="radio"/> Right arm <input type="radio"/> Left Arm <input type="radio"/> Other <input type="radio"/> Unknown
<b>2. *Date of Exam</b>	___/___/_____ (mm/dd/yyyy)

<b>3. Name of Person Who Completed this Paper Form</b>	
*First Name	_____
*Last Name	_____


**Note:** Asterisked (\*) fields indicate required data elements.


<b>1. *Facility ID Number</b>		<b>2. *Registry Case Number</b>	
<b>3. *Examination Date</b>	____/____/____ (mm/dd/yyyy)		
Rescheduled Examination?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		
Originally scheduled examination date	____/____/____ (mm/dd/yyyy)		
Rescheduled reason:	<input type="radio"/> Patient (COVID/2019 coronavirus related) <input type="radio"/> Patient (Other) <input type="radio"/> Facility (COVID/2019 coronavirus related) <input type="radio"/> Facility (Other) <input type="radio"/> Unknown		
<b>4. CTC Exam</b>			
<b>A. General</b>			
*Type of Study	Select one: <input type="radio"/> Screening OPTIONAL <input type="radio"/> Average risk (includes failed OC for reasons unrelated to increased risk of cancer [tortuosity, diverticulosis]) <input type="radio"/> High risk without symptoms (family history, etc.) <input type="radio"/> Prior resected polyp <input type="radio"/> Diagnostic without contrast <sup>?</sup> OPTIONAL <input type="radio"/> Symptoms with increased risk of cancer or neoplasm (includes abnormal FIT test) <input type="radio"/> F/u of known unresected polyps <input type="radio"/> Diagnostic with contrast <sup>?</sup> OPTIONAL <input type="radio"/> Symptoms with increased risk of cancer or neoplasm <input type="radio"/> F/u of known unresected polyps		
*Interpreting Physician	_____		
Did technique meet ACR guidelines? <sup>?</sup>	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Unknown <b>Note: If this question is answered, then the remaining fields in "Section A. General" are optional. Otherwise, they are required.</b>		
Referred from incomplete colonoscopy	<input type="radio"/> No <input type="radio"/> Yes		
CTDI <sub>vol</sub>	_____ (mGy) (Do not include scout/localizer)		
Supine Image Acquisition	<input type="radio"/> No <input type="radio"/> Yes		
Prone Image Acquisition	<input type="radio"/> No <input type="radio"/> Yes		
Decubitus Image Acquisition	<input type="radio"/> No <input type="radio"/> Yes, 1 view <input type="radio"/> Yes, 2 views		

\*Required field

B. Post Examination and Adverse Events					
*At least one polyp ≥ 10 mm	<p><input type="radio"/> No    <input type="radio"/> Yes. Please select from below, if available:</p> <p><input type="radio"/> It is unknown whether an optical colonoscopy was performed (e.g., outside medical records not available)</p> <p><input type="radio"/> Confirmed at optical colonoscopy or surgery</p> <p style="padding-left: 20px;">Histopathology of polyp(s). Select all that apply:</p> <p style="padding-left: 40px;"><input type="checkbox"/> Tubular adenoma</p> <p style="padding-left: 40px;"><input type="checkbox"/> Hyperplastic polyp</p> <p style="padding-left: 40px;"><input type="checkbox"/> Adenocarcinoma</p> <p style="padding-left: 40px;"><input type="checkbox"/> Sessile serrated adenoma</p> <p style="padding-left: 40px;"><input type="checkbox"/> Other, specify: _____ (e.g., multiple polyps)</p> <p><input type="radio"/> Not seen at optical colonoscopy or confirming surgery</p> <p><input type="radio"/> Optical colonoscopy or confirming surgery not performed</p>				
*Colonic Perforation	<p><input type="radio"/> No    <input type="radio"/> Yes, select etiology of perforation:</p> <p><input type="radio"/> Unknown</p> <p><input type="radio"/> Preceding optical colonoscopy</p> <p><input type="radio"/> Inflammatory bowel disease (IBD)</p> <p><input type="radio"/> Diverticulitis</p> <p><input type="radio"/> CTC rectal tube trauma</p> <p><input type="radio"/> Other, specify: _____</p>				
E Score	<input type="radio"/> E0 Limited examination	<input type="radio"/> E1 Normal examination or anatomic variant	<input type="radio"/> E2 Clinically unimportant finding	<input type="radio"/> E3 Likely unimportant, incompletely characterized	<input type="radio"/> E4 Potentially important finding
C Score	<input type="radio"/> C0 Inadequate study --poor prep (can't exclude > 10 mm lesions)	<input type="radio"/> C1 Normal colon or benign lesions --no polyps or polyps > 5 mm --benign lesions (lipomas, inverted diverticulum)	<input type="radio"/> C2 Intermediate polyp(s) or indeterminate lesion --polyps 6-9 mm in size, < 3 in number --indeterminate findings	<input type="radio"/> C3 Significant polyp(s), possibly advanced adenoma(s) --polyps => 10 mm --polyps 6-9 mm in size, => 3 in number	<input type="radio"/> C4 Colonic mass, likely malignant

**\*Required field**

 **Diagnostic without contrast:** Include patients with any sign or symptom that justifies a diagnostic code, e.g., anemia, blood in the stool, abnormal guaiac or FIT stool test. *It does not include asymptomatic patients who only have a history of failed optical colonoscopy, unless the optical colonoscopy was declared failed due to a visualized stricture or mass.*

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 **Did technique meet ACR guidelines?**

American College of Radiology. ACR-SAR-SCBT-MR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography (CT). 2019; Available at: <https://www.acr.org/-/media/ACR/Files/Practice-Parameters/CT-Colonog.pdf>. Accessed January 28, 2020.