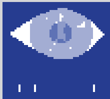


Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

INITIAL RECRUITMENT FORM
Outpatient route

Study number: ☐☐☐☐☐☐☐☐
Hospital number: ☐☐☐☐☐☐☐☐
Patient title: ______ Surname: ______
Patient forename: ______
Sex M ☐ F ☐
Date of birth: d d / m m / y y y y
Patient telephone: ______ Mobile: ______
GP Surname: ______ GP Forname: ______
GP Surgery name: ______
GP Address: ______
GP Postcode: ______ GP Telephone: ______

Please affix address label here

DETAILS OF REFERRAL (Please complete as appropriate and tick (✓) ALL that apply)

Rectal bleeding ☐ Abdominal pain ☐ Anaemia ☐ Weight loss ☐ FOBT positive ☐
Change in bowel habit ☐ Specify: ______
Other ☐ Specify: ______
Flexible sigmoidoscopy performed: Date: d d / m m / y y y y
Rigid sigmoidoscopy performed: Date: d d / m m / y y y y

OP CLINIC REQUESTING INVESTIGATION (Please complete as appropriate)

Clinic type: Colorectal surgical clinic ☐ Gastroenterology ☐
Other ☐ Specify: ______
Name of consultant: ______ Clinician seeing patient: ______
Urgency: Two week wait ☐ Urgent ☐ Soon ☐ Routine ☐
Route of Referral: GP ☐ Other ☐ Specify: ______
Date of clinic: d d / m m / y y y y Attended Clinic: Yes ☐ No ☐
If **NO**, reason: ______ New clinic date: d d / m m / y y y y

DIAGNOSES (If appropriate)

______

INVESTIGATION REQUESTED (Please tick (✓) ONE box that applies – PTO)

Colonoscopy ☐ Barium Enema ☐ Other ☐ specify: ______

CONSULTANT AGREEMENT (Please complete as appropriate)

Consultant agrees patient suitable for trial Yes ☐ No ☐
If **NO**, reason: ______
Urgency of procedure: Fast track ☐ Urgent ☐ Soon ☐ Routine ☐ N/A ☐ Comment: ______

PATIENT CONSENT (Please complete as appropriate)

Consent form: given to patient ☐ person who sent form: ______
Patient signed consent? Yes ☐ No ☐ If **NO**, reason: ______
Letter sent to GP Yes ☐ Date: d d / m m / y y y y

RANDOMISATION (Please complete as appropriate)

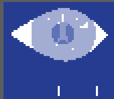
Diagnostic pathway before randomisation: Colonoscopy ☐ Barium Enema ☐
Procedure allocated after randomisation: Colonoscopy ☐ Barium Enema ☐ CT ☐
Date of exam appointment: d d / m m / y y y y Time: ☐☐:☐☐ am/pm
Date of outpatient appointment: d d / m m / y y y y Time: ☐☐:☐☐ am/pm N/A ☐

PERSON COMPLETING FORM

Name: ______ Job title: ______
Date: d d / m m / y y y y

Please return **TOP** (Grey) copy to: Prof Wendy Atkin SIGGAR1, CR-UK Colorectal Unit, St Mark's Hospital, FREEPOST LON 2069, Harrow HA1 3BR

SIGAR-OP/1/06



Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

INITIAL RECRUITMENT FORM
Radiology/Endoscopy route

Study number: ☐☐☐☐☐☐☐☐

Hospital number: ☐☐☐☐☐☐☐☐

Patient title: ☐ Surname: ____

Patient forename: ____

Sex M ☐ F ☐

Date of birth: d d/m m/y y y y

Patient telephone: ____ Mobile: ____

GP Surname: ____ GP Forname: ____

GP Surgery name: ____

GP Address: ____

GP Postcode: ____ GP Telephone: ____

Please affix address label here

ASCERTAINMENT OF PATIENT (Please tick (✓) **ONE** box that applies)

Endoscopy ☐ Radiology ☐ CT clinic ☐ A&E ☐ Other ☐ Specify: ____

INVESTIGATION REQUESTED (Please tick (✓) **ONE** box that applies – PTO)

Colonoscopy ☐ Barium Enema ☐ Other ☐ Specify: ____

REASON FOR REFERRAL (Please tick (✓) **ALL** boxes that apply – PTO)

Rectal bleeding ☐ Abdominal pain ☐ Anaemia ☐ Weight loss ☐ FOBT positive ☐

Change in bowel habit ☐ Please specify: ____

Other ☐ Specify: ____

ROUTE OF REFERRAL (Please tick (✓) ONE box that applies)

Outpatient clinic ☐ GP referral ☐ Other ☐ please specify: ____

OP CLINIC REQUESTING INVESTIGATION (only complete this section if route of referral is outpatient clinic)

Clinic type: ☐ Colorectal surgical clinic ☐ Gastroenterology ☐ Geriatrics ☐

Other ☐ Please specify: ____

Name of consultant: ____ Clinician seeing patient: ____

Date of clinic: d d/m m/y y y y

Urgency: Two week wait ☐ Urgent ☐ Soon ☐ Routine ☐

DIAGNOSES (If appropriate)

____

CONSULTANT AGREEMENT (Please complete as appropriate)

Letter sent to consultant Yes ☐ Date letter sent: d d/m m/y y y y

Consultant agrees patient suitable for trial Yes ☐ No ☐

If **NO**, reason: ____

Urgency of procedure: Fast track ☐ Urgent ☐ Soon ☐ Routine ☐ N/A ☐ Comment: ____

PATIENT CONSENT (Please complete as appropriate)

Consent form: posted to patient ☐ Date: d d/m m/y y y y person who sent form: ____

Patient signed consent? Yes ☐ No ☐ If **NO**, reason: ____

Letter sent to GP Yes ☐ Date: d d/m m/y y y y

RANDOMISATION (Please complete as appropriate)

Diagnostic pathway before randomisation: Colonoscopy ☐ Barium Enema ☐

Procedure allocated after randomisation: Colonoscopy ☐ Barium Enema ☐ CT ☐

Date of exam appointment: d d/m m/y y y y Time: ☐☐:☐☐ am/pm

Date of outpatient appointment: d d/m m/y y y y Time: ☐☐:☐☐ am/pm N/A ☐

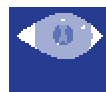
PERSON COMPLETING FORM

Name: ____ Job title: ____

Date: d d/m m/y y y y

Please return **TOP** (Grey) copy to: Prof Wendy Atkin SIGGAR1, CR-UK Colorectal Unit, St Mark's Hospital, FREEPOST LON 2069, Harrow HA1 3BR

SIG/IR-R/1/606



Lead Researchers:
Prof S. Halligan Consultant Radiologist
Prof W. Atkin Clinical Epidemiologist

The North West London Hospitals NHS Trust
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

Tel: 0208 235 4253
Fax: 0208 864 2693

Please affix address label here

CONSENT FORM

Virtual colonoscopy compared with BARIUM ENEMA for diagnosis of bowel disease

Please **INITIAL** box

1. I confirm that I have read and understand the information sheet dated May 2005 for the above study and have had the opportunity to ask questions. ☐ INITIAL
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐ INITIAL
3. I understand that sections of any of my medical notes may be looked at by responsible individuals from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. I understand that data collected in this trial may be used for future research and that I cannot be identified from this data. ☐ INITIAL
4. In principle I agree to take part in the above study. I understand that this decision is not binding at this point in time and that I have at least 24 hours further to reconsider. ☐ INITIAL

______________	______________	______________
Name of Patient	Date	Signature
______________	______________	______________
Name of researcher or person taking consent	Date	Signature

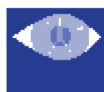
Thank you.

Please return TOP COPY in the stamped, addressed envelope provided to:
Prof Wendy Atkin. SIGGAR1 Trial, Colorectal Unit, St Mark's Hospital, Level 5, Northwick Park, Harrow. HA1 3UJ

Give one copy to the patient, put one copy in the patient's medical notes and keep one copy for your records

V.1.2-19/04/05

SIG/C/1/806



Lead Researchers:
Prof S. Halligan Consultant Radiologist
Prof W. Atkin Clinical Epidemiologist

The North West London Hospitals NHS Trust
NHS
Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ

Tel: 0208 235 4253
Fax: 0208 864 2693

Please affix address label here

CONSENT FORM

Virtual colonoscopy compared with conventional COLONOSCOPY for diagnosis of bowel disease

Please **INITIAL** box

1. I confirm that I have read and understand the information sheet dated May 2005 for the above study and have had the opportunity to ask questions. ☐ INITIAL

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐ INITIAL

3. I understand that sections of any of my medical notes may be looked at by responsible individuals from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. I understand that data collected in this trial may be used for future research and that I cannot be identified from this data. ☐ INITIAL

4. In principle I agree to take part in the above study. I understand that this decision is not binding at this point in time and that I have at least 24 hours further to reconsider. ☐ INITIAL

____________________	____________________	____________________
Name of Patient	Date	Signature
____________________	____________________	____________________
Name of researcher or person taking consent	Date	Signature

Thank you.

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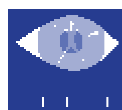
V.1.2-19/04/05

SIG/C/1/6/06



Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

BARIUM ENEMA FORM

GREEN

Study number:

Hospital number:

Patient title: Surname:

Patient forename:

Exam Date: d d m m y y y y Time: am/pm

Exam not performed: Reason:

Room Time Enter: am/pm Exit: am/pm

Procedure Time Start: am/pm Stop: am/pm

Reason/Indications:

Please affix address label here

STUDY PERFORMED BY (Please tick (✓) **ONE** box)

Reporting Radiologist ☐ Radiographer ☐ Other Consultant ☐ SpR ☐

OVERALL ASSESSMENT OF EXAMINATION (Please tick (✓) **ONE** box)

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

TECHNICAL DIFFICULTIES (Please tick (✓) where option applies)

Incontinence to barium ☐ Poor mobility ☐ Redundant colon ☐ Other ☐ Specify:

MEDICATION (Please tick (✓) as appropriate and indicate dose)

Buscopan ☐ mg Glucagon ☐ mg Other ☐ Please specify:

BOWEL PREPARATION (Please tick (✓) **ONE** box)

Excellent ☐ Good ☐ Adequate ☐ Poor ☐

ADVERSE EVENTS (Please describe – *use overleaf if necessary)*

SEGMENTAL VISUALISATION (Please compete as appropriate)

Time taken for interpretation : mins *(To the nearest half minute)*

SEGMENT (Code each box)	RM	RS	SC	DC	SF	TC	HF	AC	CM
Quality (**1** Excellent, **2** Good, **3** Adequate, **4** Poor, **8** Not Seen)									
Diverticula (**0** None, **1** Mild, **2** Moderate, **3** Severe)									

OVERALL FINDINGS WITH RESPECT TO COLONIC NEOPLASIA (Please tick (✓) where option applies)

☐ Normal If normal, confidence that there are no significant polyps or cancer (**1** Excellent, **2** Good, **3** Adequate, **4** Poor) ☐

☐ Suspected cancer or polyps *(please record below)*

REPORT ON CANCERS OR POLYPS (Please complete for **EACH** lesion seen)

Lesion	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Segment **(RM, RS, SC, DC, SF, TC, HF, AC, CM)**										
Estimated size **(mm)**										
Cancer **(C)**, Polyp **(P)** or Unsure **(U)**										
Confidence for presence of lesion (**1** Excellent, **2** Good, **3** Adequate, **4** Poor)										
If cancer **(C)**, confidence in diagnosis (**1** Excellent, **2** Good, **3** Adequate, **4** Poor)										
If polyp **(P)**, confidence not cancer (**1** Excellent, **2** Good, **3** Adequate, **4** Poor)										

OTHER FINDINGS /COMMENTS (Please describe)

ACTION (Please tick (✓) **ONE** box)

☐ Discharged ☐ Referred back to clinician ☐ Referred for another procedure

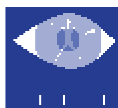
If **YES**, please specify Date: d d m m y y y y

RADIOLOGIST(S) reading films (Please **PRINT** and complete as appropriate)

Name: Grade: Name: Grade:

Please return **TOP** (Green) copy to: Prof Wendy Atkin SIGGAR1, CR-UK Colorectal Unit, St Mark's Hospital, FREEPOST LON 2069, Harrow HA1 3BR

SIG/BAR/1/606



Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

COLONOSCOPY FORM

YELLOW

Study number:
Hospital number:
Patient title: Surname:
Patient forename:
Exam Date: d d / m m / y y y y Time: : am/pm
Exam not performed: Reason:
Room Time Enter: : am/pm Exit: : am/pm
Procedure Time Start: : am/pm Stop: : am/pm
Reason/indications:

Please affix address label here

OVERALL ASSESSMENT OF EXAMINATION (Please tick (✓) ONE box only)

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

MEDICATION (Please tick (✓) ALL boxes that apply and indicate dose)

Pethidine ☐ mg Midazolam ☐ mg Fentanyl ☐ mg Buscopan ☐ mg
Other ☐ Please specify:

BOWEL PREPARATION (Please tick (✓) ONE box only)

Excellent ☐ Good ☐ Adequate ☐ Poor ☐

OVERALL FINDINGS (Please tick (✓) as appropriate)

☐ Normal
☐ Suspected cancer (record below)
☐ Polyps (record below)
☐ Other, please specify below or overleaf

COMPLETENESS OF EXAMINATION

Segment reached (RM, RS, SC, DC, SF, TC, HF, AC, CM)?
Examination complete (to caecal pole)? Yes ☐ No ☐
If **NO**, reason, please tick (✓): Pain ☐ Faeces ☐ Other ☐
If **OTHER** specify

ADVERSE EVENTS (Please describe – *use overleaf if necessary*)

POLYPS/ CANCERS/ BIOPSIES – *see overleaf for guide to filling form* (Please complete ONE line for each lesion)

Please tick (✓) **ONE** box for **EACH** question

Index	SEGMENT	Distance from Anus (cm)	SIZE (mm)	Stalk Narrow 1	Stalk Wide 2	Sessile 3	Flat or Depressed 4	Cold Biopsy 1	Hot Biopsy 2	Cold Snare 3	Hot snare 4	No Rx 5	Clin Diag PTO	Fate Biopsy PTO
A				☐	☐	☐	☐	☐	☐	☐	☐	☐		
B				☐	☐	☐	☐	☐	☐	☐	☐	☐		
C				☐	☐	☐	☐	☐	☐	☐	☐	☐		
D				☐	☐	☐	☐	☐	☐	☐	☐	☐		
E				☐	☐	☐	☐	☐	☐	☐	☐	☐		
F				☐	☐	☐	☐	☐	☐	☐	☐	☐		
G				☐	☐	☐	☐	☐	☐	☐	☐	☐		
H				☐	☐	☐	☐	☐	☐	☐	☐	☐		
I				☐	☐	☐	☐	☐	☐	☐	☐	☐		
J				☐	☐	☐	☐	☐	☐	☐	☐	☐		

SEGMENT (Code **each** box)	RM	RS	SC	DC	SF	TC	HF	AC	CM
Diverticula: (**0** None, **1** Mild, **2** Moderate, **3** Severe)									

OTHER FINDINGS/DIAGNOSES (Please describe)

ACTION (Please tick (✓) ALL boxes as appropriate)

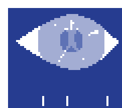
☐ **Cancer detected** (tick (✓) all as appropriate)
Refer to surgeon ☐ Procedure requested? ☐ If **YES**, please specify:
☐ **No cancer detected** (tick (✓) all as appropriate)
Refer back to clinician ☐ Exam incomplete? ☐ Specify procedure referred for:
☐ **Polyp detected:** Surveillance in years Specify exam: Check excision site in weeks
☐ **Discharged**

COMMENTS (Please describe)

Name of endoscopist: (Please PRINT) **Signature:**

Please return **TOP** (Yellow) copy to: Prof Wendy Atkin SIGGAR1, CR-UK Colorectal Unit, St Mark's Hospital, FREEPOST LON 2069, Harrow HA1 3BR

SIG/COL/1/606



Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

CT COLONOGRAPHY FORM

BLUE

Study number:

Hospital number:

Patient title: Surname:

Patient forename:

Exam Date: d d / m m / y y y y Time: am/pm

Exam not performed: Reason:

Room Time Enter: am/pm Exit: am/pm

Procedure Time Start: am/pm Stop: am/pm

Reason/Indications:

Please affix address label here

STUDY PERFORMED BY (Please tick (✓) **ONE** box)

Reporting Radiologist ☐ Radiographer ☐ Other Consultant ☐ SpR ☐

OVERALL ASSESSMENT OF EXAMINATION (Please tick (✓) **ONE** box)

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

MEDICATION (Please tick (✓) as appropriate and indicate dose)

Buscopan ☐ mg Glucagon ☐ mg Other ☐ Please specify:

BOWEL PREPARATION (Please tick (✓) **ONE** box)

Excellent ☐ Good ☐ Adequate ☐ Poor ☐

EXAMINATION (Please tick (✓) where option applies)

Slice Collimation: mm (1-5) No. of detector rows (4-64)

Scans obtained: Prone ☐ Supine ☐ Gas: Carbon Dioxide ☐ Air ☐

Intravenous contrast administered? ☐ Oral labeling used? ☐ Mechanical insufflators used? ☐

TECHNICAL DIFFICULTIES (Please tick (✓) where option applies)

Incontinence to gas ☐ Poor mobility ☐ Other ☐ Specify: ☐

ADVERSE EVENTS (Please describe – *use overleaf if necessary*)

SEGMENTAL VISUALISATION (for prone & supine scans combined)

Time taken for interpretation : mins Proportion of 2D to 3D reading (e.g. 80:20)

Reading platform used, please specify (e.g. Voxar, Vitrea, GE):

SEGMENT (Code each box)	RM	RS	SC	DC	SF	TC	HF	AC	CM
Quality (**1** Excellent, **2** Good, **3** Adequate, **4** Poor, **8** Not Seen)									
Diverticula (**0** None, **1** Mild, **2** Moderate, **3** Severe)									

OVERALL FINDINGS WITH RESPECT TO COLONIC NEOPLASIA (Please tick (✓) where option applies)

☐ Normal. If **normal**, confidence that there are no significant polyps or cancer (**1** Excellent, **2** Good, **3** Adequate, **4** Poor) ☐

☐ Suspected cancer or polyps *(please record below)*

REPORT ON CANCERS OR POLYPS (Please complete for **EACH** lesion seen)

Lesion	**A**	**B**	**C**	**D**	**E**	**F**	**G**	**H**	**I**	**J**
Segment **(RM, RS, SC, DC, SF, TC, HF, AC, CM)**										
Estimated size **(mm)**										
Cancer **(C)**, Polyp **(P)** or Unsure **(U)**										
Confidence for presence of lesion (**1** Excellent, **2** Good, **3** Adequate, **4** Poor)										
If cancer **(C)**, confidence in diagnosis (**1** Excellent, **2** Good, **3** Adequate, **4** Poor)										
If polyp **(P)**, confidence not cancer (**1** Excellent, **2** Good, **3** Adequate, **4** Poor)										

OTHER COLONIC FINDINGS (Please describe)

EXTRA COLONIC FINDINGS (Please complete as appropriate)

	Abnormality seen (e.g. size of aortic aneurysm)	Details of any further action suggested on report
1		
2		

ACTION (Please tick (✓) **ONE** box)

☐ Discharged ☐ Referred back to clinician ☐ Referred for another procedure

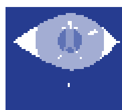
If **YES**, please specify Date: d d / m m / y y y y

RADIOLOGIST(S) reporting CT (Please **PRINT** and complete as appropriate)

Name: Grade: Name: Grade:

Please return **TOP** (Blue) copy to: Prof Wendy Atkin SIGGAR1, CR-UK Colorectal Unit, St Mark's Hospital, FREEPOST LON 2069, Harrow HA1 3BR

SIG/CTCOL/1/06



Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

FLEXIBLE SIGMOIDOSCOPY FORM

Study number: ☐☐☐☐☐☐☐☐

Hospital number: ☐☐☐☐☐☐☐☐

Patient title: ☐ Surname: ☐

Patient forename: ☐

Exam Date: d d / m m / y y y y Time: ☐☐:☐☐ am/pm

Exam not performed: ☐ Reason: ☐

Room Time Enter: ☐☐:☐☐ am/pm Exit: ☐☐:☐☐ am/pm

Procedure Time Start: ☐☐:☐☐ am/pm Stop: ☐☐:☐☐ am/pm

Reason/indications: ☐

Please affix address label here

OVERALL ASSESSMENT OF EXAMINATION (Please tick (✓) ONE box only)

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

BOWEL PREPARATION (Please tick (✓) ONE box only)

Excellent ☐ Good ☐ Adequate ☐ Poor ☐

OVERALL FINDINGS (Please tick (✓) as appropriate)

☐ Normal
☐ Suspected cancer (record below)
☐ Polyps (record below)
☐ Other, please specify below or overleaf

PINK

COMPLETENESS OF EXAMINATION

Segment reached (RM, RS, SC, DC, SF, TC)? ☐☐

Examination complete (to SC/DC junction)? Yes ☐ No ☐

If **NO**, reason, please tick (✓): Pain ☐ Faeces ☐ Other ☐

specify: ☐

Maximum shaft insertion? ☐☐ cm

ADVERSE EVENTS (Please describe – *use overleaf if necessary)*

POLYPS/ CANCERS/ BIOPSIES – *see overleaf for guide to filling form* (Please complete ONE line for each lesion)

Please tick (✓) **ONE** box for **EACH** question

LESION	SEGMENT	Distance from Anus (cm)	SIZE (mm)	Stalk Narrow 1	Stalk Wide 2	Sessile 3	Flat or Depressed 4	Cold Biopsy 1	Hot Biopsy 2	Cold Snare 3	Hot snare 4	No Rx 5	Clin Diag PTO	Fate Biopsy PTO
A				☐	☐	☐	☐	☐	☐	☐	☐	☐		
B				☐	☐	☐	☐	☐	☐	☐	☐	☐		
C				☐	☐	☐	☐	☐	☐	☐	☐	☐		
D				☐	☐	☐	☐	☐	☐	☐	☐	☐		
E				☐	☐	☐	☐	☐	☐	☐	☐	☐		
F				☐	☐	☐	☐	☐	☐	☐	☐	☐		
G				☐	☐	☐	☐	☐	☐	☐	☐	☐		
H				☐	☐	☐	☐	☐	☐	☐	☐	☐		
I				☐	☐	☐	☐	☐	☐	☐	☐	☐		
J				☐	☐	☐	☐	☐	☐	☐	☐	☐		

SEGMENT (Code **each** box)	RM	RS	SC	DC	SF	TC	HF	AC	CM
Diverticula: (**0** None, **1** Mild, **2** Moderate, **3** Severe)									

OTHER FINDINGS/DIAGNOSES (Please describe)

ACTION (Please tick (✓) ALL boxes as appropriate)

☐ **Cancer detected** (tick (✓) all as appropriate)

Refer to surgeon ☐ Procedure requested? ☐ If **YES**, please specify: ☐

☐ **No cancer detected** (tick (✓) all as appropriate)

Refer back to clinician ☐ Exam incomplete? ☐ Specify procedure referred for: ☐

☐ **Polyp detected:** Surveillance in ☐ years Specify exam: ☐ Check excision site in ☐ weeks

☐ **Discharged**

COMMENTS (Please describe)

Name of endoscopist: (Please PRINT) ☐ **Signature:** ☐

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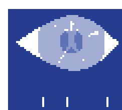
SIGFS/1/606



Special Interest Group in Gastrointestinal & Abdominal Radiology

V.21/04/06

SURGICAL RECORD FORM

Study number: [ ]

Hospital number: [ ]

Patient title: [ ] Surname: [ ]

Patient forename: [ ]

Procedure not performed [ ] Reason: [ ]

Reason/indications: [ ]

Date of operation: d d / m m / y y y y

Time: [ ] : [ ] am/pm

Please affix address label here

Surgeon name: [ ] Grade: [ ]

Assistant name: [ ] Grade: [ ]

OPERATION RECORD (Please tick (✓) as appropriate)

Site(s) of lesion: RM [ ] RS [ ] SC [ ] DC [ ] SF [ ] TC [ ] HF [ ] AC [ ] CM [ ] Anus [ ] Appendix [ ]

Intra-operative colonoscopy No [ ] Yes [ ]

Indication: Curative [ ] Palliative [ ] Unsure [ ] Other, specify: [ ]

Specify operation type: [ ]

Please tick (✓) as appropriate:

	Specify type:		
[ ] Anastomosis:			
[ ] Metastasis:	[ ] Liver	[ ] Peritoneal	[ ] Other, specify [ ]
[ ] Stoma Ileostomy:	[ ] Temporary	[ ] Permanent	
[ ] Stoma Colostomy:	[ ] Temporary	[ ] Permanent	

POST-OPERATIVE COURSE

Length of hospital stay [ ] days

If >16 days, give reason: [ ]

MAJOR COMPLICATIONS (Please tick (✓) as appropriate)

	Pease specify treatment
[ ] Anastomotic leak	
[ ] Burst abdomen (requiring resuture)	
[ ] Wound infection (delaying discharge)	
[ ] Other, please specify:	

OTHER COMMENTS: (attach clinical records where relevant)

Signature of Surgeon: [ ]

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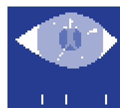
GOLD



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OUTPATIENT FOLLOW-UP FORM

Study number:
Hospital number:
Patient title: Surname:
Patient forename:
Sex M ☐ F ☐
Appointment date: d d / m m / y y y y
Appointment time: am/pm
Did not attend ☐ Reason:

Please affix address label here

WHITE

OP APPOINTMENT DETAILS (Please complete as appropriate)

Consultant in charge of clinic:
Name of clinician seeing patient (if different from above):

CLINICAL HISTORY (Please fill in ALL exams that the patient has had – first procedure is initial randomised procedure)

Randomised Procedure (Please tick (✓) one): Colonoscopy ☐ Barium Enema ☐ CT ☐

List other procedures below (in the order in which they took place):

2	4	6
3	5	7

COLONIC FINDINGS AT OR AFTER RANDOMISED PROCEDURE (Pleaase tick (✓) ALL boxes that apply)

☐ Cancer, please specify: suspected cancer ☐ confirmed cancer ☐
☐ Polyps, please specify: polyps detected ☐ polyps removed ☐ confirmed adenomas ☐
☐ Other abnormality, please specify:
☐ No abnormality detected

EXTRA COLONIC FINDINGS FROM CT COLONOGRAPHY AT OR AFTER RANDOMISED PROCEDURE (If relevant)

Outpatient consultant/clinician's decision on extra colonic findings (Please tick (✓) **ONE** box that applies):
☐ Incidental to patient's symptoms but I feel obliged to investigate
☐ Incidental to patient's symptoms and I am going to ignore this finding
☐ Cause of symptoms, therefore pursue this line of investigation

PROCEDURES/TESTS PERFORMED AT OUTPATIENT CLINIC (Please complete overleaf if more than one)

Procedure/Test | Details or reason why test performed

ACTION (Please complete as appropriate and tick (✓) ALL boxes that apply)

☐ **Discharge from clinic?** ☐ **Watch and wait?** – see again in Months Date: d d / m m / y y y y
☐ Cancer found, specify treatment:
☐ Refer for colonic test(s) If **YES**, specify test, reason and date of appointment if known
Date: d d / m m / y y y y
Date: d d / m m / y y y y
☐ Refer for non colonic test(s) If Yes, specify test, reason and date of appointment if known
Date: d d / m m / y y y y
Date: d d / m m / y y y y

ANY OTHER COMMENTS

PERSON COMPLETING FORM

Name: Job title:
Date: d d / m m / y y y y

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