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

1. Date Abstracted: ____________________________
   Month   Day   Year

2. Abstractor ID#: ___ ___ ___ ___

3. CTR ID: ___ ___ ___ ___

4. Study Year T0-T13: ___ ___

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

FOR OFFICE USE ONLY

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

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

   **Data Retrieval:**
   - Attempted
   - None Required

   **Disposition:**
   - Interim Complete (ICM)
   - Final Complete (FCM)
   - Final Incomplete (FIC)
### PART A: INITIAL TREATMENT INFORMATION

1. **SURGICAL TREATMENT FOR COLORECTAL CANCER:**
   - ○ No
   - ○ Yes (COMPLETE TABLE BELOW)
   - ○ Unknown

<table>
<thead>
<tr>
<th>PROCEDURE #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF SURGICAL PROCEDURE</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
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<tr>
<td>(SEE SURGICAL PROCEDURE CODES BELOW. IF OTHER, SPECIFY)</td>
<td>01 = Local excision (includes local transanal excision)</td>
<td>03 = Surgical resection with reanastomosis</td>
<td>04 = Surgical resection with colostomy</td>
<td>06 = Bypass surgery or palliative resection</td>
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<td></td>
<td>07 = Cryosurgery</td>
<td>08 = Lymphadenectomy/Lymph node sampling</td>
<td>09 = Appendectomy (for appendiceal primaries only)</td>
<td>10 = Laser ablation</td>
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<td></td>
<td>88 = Other (SPECIFY)</td>
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<td></td>
<td></td>
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<tr>
<td>DATE OF SURGERY (MO.-DAY-YEAR)</td>
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**SURGICAL PROCEDURE CODES**
- 01 = Local excision (includes local transanal excision)
- 03 = Surgical resection with reanastomosis
- 04 = Surgical resection with colostomy
- 06 = Bypass surgery or palliative resection
- 07 = Cryosurgery
- 08 = Lymphadenectomy/Lymph node sampling
- 09 = Appendectomy (for appendiceal primaries only)
- 10 = Laser ablation
- 88 = Other (SPECIFY)

2. **RADIATION TREATMENT FOR COLORECTAL CANCER:**
   - ○ No
   - ○ Yes (COMPLETE TABLE BELOW)
   - ○ Unknown

<table>
<thead>
<tr>
<th>TREATMENT #</th>
<th>1</th>
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<tbody>
<tr>
<td>DATE RADIATION TREATMENT BEGAN (MO.-DAY-YEAR)</td>
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3. CHEMOTHERAPEUTIC TREATMENT FOR COLORECTAL CANCER:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)
   ○ Unknown

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<td>DATE CHEMOTHERAPEUTIC TREATMENT BEGAN (MO.-DAY-YEAR)</td>
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4. OTHER TYPE OF TREATMENT FOR COLORECTAL CANCER:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)
   ○ Unknown

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5. ANY LOCAL OR REGIONAL RESIDUAL DISEASE LEFT AFTER SURGERY:
   ○ No
   ○ Yes – Microscopic
   ○ Yes – Gross Tumor
   ○ Not applicable
   ○ Unknown
PART B: PHYSICIAN/HOSPITAL LOCATION INFORMATION

6. PHYSICIAN FOR TREATMENT:
   a. Name: _________________________________________________________________________________
   Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________
   b. Name: _________________________________________________________________________________
   Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________

7. HOSPITAL OR CLINIC FOR TREATMENT:
   a. Name: _________________________________________________________________________________
   Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________
   b. Name: _________________________________________________________________________________
   Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________

8. COMMENTS:
   ○ No
   ○ Yes (SPECIFY)

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<tr>
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   ○ (CONTINUED)