

SCOAP Data Collection Form For Adults (Effective starting with 04.08 Discharges)

Instructions: Complete Pages 1-3 for all patients who have an appendectomy, bariatric operation, or colon surgery at your hospital. Complete Page 4 *only for the appropriate operation.* Complete one form for each procedure.

First initial of Last Name/F.I. of First Name: ____ / ____ **Hospital record # (optional):** _____

Date of Birth: ____ / ____ / ____

Admit Date: ____ / ____ / ____

Discharge Date: ____ / ____ / ____

Gender: Male Female

Age at Admit: ____ (years)

Patient Height: ____ (in) OR ____ (cm) NA

Weight: ____ (lbs) OR ____ (kg) NA

Primary Insurance:

Private: *If private, choose one:* Regence Premera First Choice Group Health Aetna Cigna
 Uniform Medical United Healthcare Kaiser Other Private

Medicare Medicaid TriCare
 Indian Health Svcs VA beneficiary
 Uninsured/self pay

Residence Zip Code: _____ NA

1) Current cigarette smoker: (within the past year) No Yes

2) Most recent laboratory values within 30 days of or upon admission:

Albumin: ____ Gm/dl NA Creatinine: ____ mg/dl NA Hgb: ____ g/dl NA WBC: ____ 10³ NA

3) Current / recent medications used:

No Yes Immunosuppressant
 No Yes Statin
 No Yes Beta Blocker
 No Yes ACE inhibitor or ARB
 No Yes Therapeutic anticoagulation within 1 week of surgery

4) Home O₂ use: No Yes

5) Home mobility device use: No Yes

6) Comorbidities:

<input type="radio"/> No <input type="radio"/> Yes Hypertension	<i>If yes, check the best response</i> <input type="radio"/> No meds <input type="radio"/> Single med <input type="radio"/> Multiple meds <input type="radio"/> No meds <input type="radio"/> Single non-insulin <input type="radio"/> Multiple non-insulin <input type="radio"/> Insulin <input type="radio"/> Insulin plus other meds <input type="checkbox"/> Steroid use <input type="checkbox"/> Inhalants <input type="checkbox"/> None <input type="radio"/> CPAP <input type="radio"/> None <input type="checkbox"/> History MI <input type="checkbox"/> PCI, CABG, AICD <input type="checkbox"/> None
<input type="radio"/> No <input type="radio"/> Yes Diabetes	
<input type="radio"/> No <input type="radio"/> Yes Asthma	
<input type="radio"/> No <input type="radio"/> Yes History of sleep apnea	
<input type="radio"/> No <input type="radio"/> Yes Coronary artery disease	
<input type="radio"/> No <input type="radio"/> Yes History of VTE	
<input type="radio"/> No <input type="radio"/> Yes HIV / AIDS	

7) Primary Surgeon: _____ (Optional; use physician ID # only – NO names)

8) Indication for operation: *Check all that apply within each category*

For appendectomy:	For bariatric surgery:	For colon:
<input type="radio"/> Appendicitis <input type="radio"/> Appendiceal mass / cancer <input type="radio"/> Other (specify): _____ 	<input type="radio"/> Morbid obesity <input type="radio"/> Other (specify): _____ 	<input type="radio"/> Cancer of colon <input type="radio"/> Diverticulitis <input type="radio"/> Trauma <i>If trauma, <input type="radio"/> blunt <input type="radio"/> penetrating</i> <input type="radio"/> Radiation colitis <input type="radio"/> Volvulus <input type="radio"/> Arteriovenous malformation <input type="radio"/> Ischemic colon <input type="radio"/> Other: (specify) _____
		<input type="radio"/> GI bleeding <input type="radio"/> Perforation <input type="radio"/> Cancer of rectum <input type="radio"/> Bowel obstruction <input type="radio"/> Colostomy <input type="radio"/> Ulcerative colitis <input type="radio"/> Crohn's disease <input type="radio"/> Stricture

9) Time of first incision: _____:_____ (24-hr clock) NA

10) In-room close time: _____:_____ (24-hr clock) NA

11) Date of surgery: ____/____/____

11) In-room close date: ____/____/____

13) Surgical approach: Laparoscopic Lap converted to open Lap, hand-assisted Open (no lap ports)

14) ASA Class: I II III IV Already intubated NA

If procedure is appendectomy, skip questions 15 - 18

15) Insulin used in OR: No Yes

16) Highest perioperative blood glucose: _____ mg Not performed

17) Lowest intra-op temperature: _____°C NA

17.5) Death in the OR: No Yes

18) First temperature on arrival to recovery room: _____°C Not applicable if death in the OR

19) Perioperative interventions: *Check all that apply. Skip all DVT prophylaxis questions if procedure is appendectomy*

DVT Prophylaxis: Heparin or low molecular weight heparin or synthetic factor Xa administered: *(Not applicable if apply)*

- **Within 24 hours of incision:** No Yes

If yes; Heparin _____ units Frequency: × 1 only **OR** q _____ hrs
 Enoxaparin (Lovenox) _____ mg Frequency: × 1 only **OR** q _____ hrs
 Dalteparin (Fragmin) _____ IU Frequency: × 1 only **OR** q _____ hrs
 Tinzaparin (Innohep) _____ Units Frequency: × 1 only **OR** q _____ hrs
 Fondaparinux (Aristra) _____ mg Frequency: × 1 only **OR** q _____ hrs

If no; was there a contraindication documented? No Yes

- **Ordered post-op for in-hospital use after the first 24 hrs:** No Yes *(Not applicable if death in O.R.)*

If yes; Heparin _____ units Frequency: × 1 only **OR** q _____ hrs × _____ days **OR** daily
 Enoxaparin (Lovenox) _____ mg Frequency: × 1 only **OR** q _____ hrs × _____ days **OR** daily
 Dalteparin (Fragmin) _____ IU Frequency: × 1 only **OR** q _____ hrs × _____ days **OR** daily
 Tinzaparin (Innohep) _____ Units Frequency: × 1 only **OR** q _____ hrs × _____ days **OR** daily
 Fondaparinux (Aristra) _____ mg Frequency: × 1 only **OR** q _____ hrs × _____ days **OR** daily
 Coumadin _____ mg Frequency: × 1 only **OR** q _____ hrs × _____ days **OR** daily

If no; was there a contraindication documented? No Yes

- **Ordered on discharge:** No Yes *(Not applicable if discharge disposition is death)*

If yes; Heparin _____ units Frequency: q _____ hrs × _____ days
 Enoxaparin (Lovenox) _____ mg Frequency: q _____ hrs × _____ days
 Dalteparin (Fragmin) _____ IU Frequency: q _____ hrs × _____ days
 Tinzaparin (Innohep) _____ Units Frequency: q _____ hrs × _____ days
 Fondaparinux (Aristra) _____ mg Frequency: q _____ hrs × _____ days
 Coumadin _____ mg Frequency: q _____ hrs × _____ days

If no; was there a contraindication documented? No Yes

Intermittent pneumatic compression in O.R.: *(not applicable if apply)* No Yes

Patient Initials: _____

Date of Birth: _____

Admit Date: _____

Beta-blocker:

Administered within 24 hrs pre-op: No Yes

Ordered within 24 hrs post-op: No Yes (not applicable if death in O.R.)

Antibiotics: (not applicable if apply)

On antibiotics for the treatment of infection:

No Yes

If yes: At this hospital:

No Yes

At transferring hospital:

No Yes

Were prophylactic antibiotics indicated:

No Yes

If yes: Administered within 60 min of incision:

No Yes

Discontinued within 24 hrs after closure:

No Yes (not applicable if death in O.R.)

Pain management: (Not applicable if apply or death in the O.R.)

Epidural ordered within 24 hrs post-op: No Yes Contraindicated

PCA ordered within 24 hrs post-op: No Yes Contraindicated

NSAID ordered within 24 hrs post-op: No Yes Contraindicated

Narcotic drip: No Yes Contraindicated

Other: No Yes If yes, specify modality: _____

Nasogastric tube: (Not applicable if death in the O.R.)

Left O.R. with NG tube in place: No Yes

Left O.R. with G tube to drainage in place: No Yes

Red blood cell transfusion: (Not applicable if apply)

In O.R. or within 24 hrs post-op: No Yes If yes, how many units? _____

Mechanical ventilation:

Beyond recovery room No Yes If yes, total hours: _____ hrs Not applicable – chronic ventilator pt

- 20) Discharge disposition:** Home SNF Death: if yes, specify: Death in the O.R.
 Rehab facility Other acute care hospital Death within 24 hrs post-op
 Other location Death after 24 hrs post-op

21) Reintervention: If the patient had any of the surgical operations or therapies listed below during this hospitalization and following the abdominal procedure, select all that apply and note the date first performed after surgery. (Not applicable if death in the O.R.)

None

Abdominal re-operation: If yes, specify procedure

Colostomy or ileostomy _____/_____/_____ (mm/dd/yyyy)

Abscess drainage _____/_____/_____

Operative drain placement _____/_____/_____

Gastrostomy _____/_____/_____

Gastrostomy revision _____/_____/_____

Re-exploration/washout _____/_____/_____

Anastomotic revision _____/_____/_____

Band replacement _____/_____/_____

Band/port revision _____/_____/_____

Wound revision or evisceration _____/_____/_____

Negative re-exploration _____/_____/_____

Other (specify: _____) _____/_____/_____

Tracheal reintubation _____/_____/_____

NG tube replacement (non-routine) _____/_____/_____

Tracheostomy _____/_____/_____

Placement of percutaneous drain _____/_____/_____

Anticoagulation therapy for presumed/confirmed DVT

Anticoagulation therapy for presumed/confirmed PE

Antibiotic for presumed/confirmed infection

Wound reopened

Radiologically demonstrated anastomotic leak

Radiologically demonstrated enterocutaneous fistula

Other (specify : _____)

Complete only for the appropriate operation. Complete one form for each separate admission.

Bariatric

22) Prior foregut surgery: No Yes

23) Procedure of record: Gastric bypass (proximal)
 Gastric bypass (distal)
 Sleeve gastrectomy
 Biliopancreatic bypass
 Biliopancreatic bypass with duodenal switch
 Adjustable Lap Band *Specify size:* 9.5 cm 10 cm
 11 cm Other _____ cm
 AP Standard AP Large
 NA

24) Stomach divided: No Yes not applicable for lap band operations

25) Anastomosis tested: No Yes not applicable for lap band operations
If yes, indicate how tested: Scope
 Methylene blue
 Air/saline injected via tube or syringe
 Palpation/inspection
 Other (*specify:* _____)

Non-elective Appendectomy:

26) Concurrent abdominal or pelvic procedure performed (e.g. colectomy, ovarian cystectomy): No Yes
If yes, specify: Gynecologic Colon Gall bladder Other

27) Pre-op imaging within 24 hrs: No Yes
If yes, specify: CT scan Ultrasound
If yes, results were: Consistent with appendicitis Not consistent with appendicitis Indeterminate

28) ER/urgent care visit within one week prior to operation: No Yes

29) Pathology results: appendiceal pathology No Yes

30) Perforated appendix: No Yes

Colon Operation:

31) Prior colon or pelvic surgery: No Yes

32) Prior colon resection within 30 days? No Yes

If yes, indicate at which hospital performed _____

33) Procedure priority: Elective Non-elective

34) Operation type: Rt hemicolectomy Lf hemicolectomy Low anterior resection
 Abdominal Perineal Resection (APR) Total abdominal colectomy Colostomy takedown

35) Ostomy: No ostomy Colostomy Ileostomy Protective stoma

36) Anastomosis: No Yes *If yes, specify:* Colocolon (colon to colon) Ileocolon (ileum to colon)
 Ileoanal (ileum to anal) Coloanal (colon to anal)
 Cannot be determined

If ileoanal or coloanal anastomosis, pouch created: No Yes

37) Anastomosis tested: No Yes *If yes, specify:* Scope (flexible endoscopy or sigmoidoscope) Methylene blue
 Air/saline injected via tube or syringe Palpation/inspection
 Other (*specify:* _____)

Complete questions 38 – 43 only if diagnosis for colon surgery is cancer.

38) Pathology results confirm diagnosis: No Yes

39) Number of lymph nodes removed and studied: _____

40) Number of lymph nodes positive for cancer: _____

41) Metastatic disease beyond lymph nodes, e.g. liver, diaphragm, peritoneum: No Yes

42) Margins free of cancer: No Yes *If yes, cm to distal margin:* <1 cm 1-2 cm >2 cm NA
cm to proximal margin: <1 cm 1-2 cm >2 cm NA

Patient Initials: _____

Date of Birth: _____

Admit Date: _____

43) T stage: T₁ T₂ T₃ T₄ NA