



EGD Data Collection Form

***= Required Data Field**

CR = Conditionally Required

Patient Sociodemographic Information

Patient Identifier*:

Patient Type*:	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient															
Patient Zip Code*:	<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>							Patient Birth Date*: <table border="1"> <tr> <td>m</td><td>m</td><td>d</td><td>d</td><td>y</td><td>y</td><td>y</td><td>y</td> </tr> </table>	m	m	d	d	y	y	y	y
m	m	d	d	y	y	y	y									
Patient Sex at Birth*:	<input type="checkbox"/> Male <input type="checkbox"/> Female															
Patient Height: (inches)	<table border="1"> <tr> <td></td><td></td> </tr> </table>			Patient Weight: (pounds) <table border="1"> <tr> <td></td><td></td><td></td> </tr> </table>												
Patient Race*:	<input type="checkbox"/> American Indian (Native American) or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Patient declined to provide <input type="checkbox"/> Unknown <input type="checkbox"/> Other															
Patient Ethnicity*:	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Patient declined to provide <input type="checkbox"/> White															
Patient Insurance Type:	<input type="checkbox"/> Aetna <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Cigna <input type="checkbox"/> Humana <input type="checkbox"/> United Healthcare <input type="checkbox"/> Wellpoint <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Medicare Fee for Service															



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- Medicaid
- Tricare
- None
- Other (list specific name of plan if not listed above): _____

Endoscopy Suite Information

Endoscopy Facility ID*:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Endo Suite Type*: <input type="checkbox"/> Hospital <input type="checkbox"/> ASC/AEC <input type="checkbox"/> Physician Office	
Physician ID*:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Endo Suite Teaching Status:	<input type="checkbox"/> Teaching Facility <input type="checkbox"/> Non-Teaching Facility
Fellow Physician ID (NPI):	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Did the Fellow Physician perform the procedure in its entirety? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No
Year of Fellowship ^{CR} :	<input type="checkbox"/> Year 1 <input type="checkbox"/> Year 2 <input type="checkbox"/> Year 3 <input type="checkbox"/> Year 4	Physician Specialty	<input type="checkbox"/> GI <input type="checkbox"/> IM <input type="checkbox"/> FP <input type="checkbox"/> Surgeon <input type="checkbox"/> Other

General Quality Indicators

Procedure Date*:	<input type="text"/> m <input type="text"/> m <input type="text"/> d <input type="text"/> d <input type="text"/> y <input type="text"/> y <input type="text"/> y <input type="text"/> y
Endoscopy Procedure*:	<input type="checkbox"/> Colonoscopy <input type="checkbox"/> EGD <input type="checkbox"/> ERCP <input type="checkbox"/> EUS
Current History & Physical Documented in Medical Record?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is <i>H. pylori</i> status known or unknown?*	<input type="checkbox"/> Known <input type="checkbox"/> Unknown
Is the patient on anti-platelet or anticoagulation therapy, other than use of aspirin / NSAIDs?*	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Is the patient on aspirin / NSAID therapy?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Informed Consent Documented in Medical Record?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
ASA Category*:	<input type="checkbox"/> ASA I <input type="checkbox"/> ASA II <input type="checkbox"/> ASA III <input type="checkbox"/> ASA IV <input type="checkbox"/> ASA V <input type="checkbox"/> ASA-E
Sedation type:	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Deep (propofol) <input type="checkbox"/> General
Sedation administered by^{CR}:	<input type="checkbox"/> Nurse <input type="checkbox"/> Endoscopist <input type="checkbox"/> Anesthesia professional
Endoscope used:	Brand: <input type="checkbox"/> Fujinon <input type="checkbox"/> Olympus <input type="checkbox"/> Pentax <input type="checkbox"/> Other: _____

Discharge Instructions

Note: If the procedure is for an inpatient, please fill out only the questions on Diet Instructions and Medication Resumption. If the procedure is for an outpatient, please fill out all the instruction questions below.

Written <u>Discharge Instructions</u> provided to patient before discharge?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diet Instructions^{CR}:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Resumption / Orders Given^{CR}:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Return to Activities^{CR}:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Potential Delayed Complications^{CR}:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Emergency Contact Number^{CR}:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anticoagulation / Anti-platelet Therapy	
Anticoagulation / Anti-platelet Therapy: Patient given instructions relative to resumption of therapy (not including aspirin / NSAID therapy)*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Aspirin / NSAID Therapy: Patient given instructions relative to resumption of therapy*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

EGD Procedure Quality Indicators

EGD Indication* – Select at least one (1) reason for performing the EGD

<input type="checkbox"/>	Upper abdominal symptoms that persist despite an appropriate trial of therapy
<input type="checkbox"/>	Upper abdominal symptoms associated with other symptoms or signs suggesting structural disease (e.g., anorexia and weight loss) or new-onset symptoms in patients >50 years old



EGD Data Collection Form

<input type="checkbox"/>	Dysphagia or odynophagia
<input type="checkbox"/>	Esophageal reflux symptoms that persist or recur despite appropriate therapy
<input type="checkbox"/>	Persistent vomiting of unknown cause
<input type="checkbox"/>	Other diseases in which the presence of upper GI pathologic conditions might modify other planned management (examples include patients who have a history of ulcer or GI bleeding who are scheduled for organ transplantation, long-term anticoagulation, or long-term nonsteroidal anti-inflammatory drug therapy for arthritis, and those with cancer of the head and neck)
<input type="checkbox"/>	Familial adenomatous polyposis syndromes
<input type="checkbox"/>	For confirmation and specific histologic diagnosis of radiologically demonstrated lesions <ol style="list-style-type: none"> 1. Suspected neoplastic lesion 2. Gastric or esophageal ulcer 3. Upper tract stricture or obstruction
<input type="checkbox"/>	GI bleeding <ol style="list-style-type: none"> 1. In patients with active or recent bleeding 2. For presumed chronic blood loss and for iron deficiency anemia when the clinical situation suggests an upper GI source or when colonoscopy does not provide an explanation
<input type="checkbox"/>	When sampling of tissue or fluid is indicated
<input type="checkbox"/>	In patients with suspected portal hypertension to document or treat esophageal varices
<input type="checkbox"/>	To assess acute injury after caustic ingestion
<input type="checkbox"/>	To assess diarrhea in patients suspected of having small-bowel disease (e.g., celiac disease)
<input type="checkbox"/>	Treatment of bleeding lesions such as ulcers, tumors, vascular abnormalities (e.g., electrocoagulation, heater probe, laser photocoagulation, or injection therapy)
<input type="checkbox"/>	Removal of foreign bodies
<input type="checkbox"/>	Removal of selected lesions
<input type="checkbox"/>	Placement of feeding or drainage tubes (e.g., peroral, percutaneous endoscopic gastrostomy, percutaneous endoscopic jejunostomy)
<input type="checkbox"/>	Dilation and stenting of stenotic lesions (e.g., with transendoscopic balloon dilators or dilation systems using guidewires)
<input type="checkbox"/>	Management of achalasia (e.g., botulinum toxin, balloon dilation)
<input type="checkbox"/>	Palliative treatment of stenosing neoplasms (e.g., laser, multipolar electrocoagulation, stent placement)
<input type="checkbox"/>	Endoscopic therapy of Barrett's esophagus / intestinal metaplasia
<input type="checkbox"/>	Barrett's esophagus with intramucosal cancer



EGD Data Collection Form

<input type="checkbox"/>	Barrett's esophagus with high-grade dysplasia
<input type="checkbox"/>	Barrett's esophagus with low-grade dysplasia
<input type="checkbox"/>	Barrett's esophagus without dysplasia
<input type="checkbox"/>	Intraoperative evaluation of anatomic reconstructions typical of modern foregut surgery (e.g., evaluation of anastomotic leak and patency, fundoplication formation, pouch configuration during bariatric surgery)
<input type="checkbox"/>	Management of operative complications (e.g., dilation of anastomotic strictures, stenting of anastomotic disruption, fistula, or leak in selected circumstances)
<input type="checkbox"/>	Screening for Barrett's esophagus
<input type="checkbox"/>	Surveillance of Barrett's esophagus
<input type="checkbox"/>	Surveillance after eradication of Barrett's esophagus
<input type="checkbox"/>	Surveillance for malignancy in patients with premalignant conditions other than Barrett's esophagus (e.g. polyposis syndromes, gastric adenomas, tylosis, or previous caustic ingestion).
<input type="checkbox"/>	Evaluation of eosinophilic esophagitis
<input type="checkbox"/>	Other, specify: _____

Placement of Percutaneous Enteral Feeding Tube

Was a percutaneous enteral feeding tube placed?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, did the patient receive antibiotic therapy in the 24 hours before the procedure? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No
GI Bleeding	
Did the patient demonstrate a spurting visible vessel, an oozing visible vessel or a non-bleeding visible vessel? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the patient receive endoscopic hemostatic therapy by any modality? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there a finding of esophageal varices AND EITHER active bleeding OR stigmata of recent hemorrhage? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did the patient undergo esophageal variceal band ligation? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No



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Tissue Sampling / Removal

Device(s) used for biopsy or other tissue removal:	<input type="checkbox"/> Biopsy forceps - cold <input type="checkbox"/> Snare – endoscopic mucosal resection <input type="checkbox"/> Snare – endoscopic submucosal dissection <input type="checkbox"/> Radiofrequency ablation <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Injection <input type="checkbox"/> Other <input type="checkbox"/> N/A
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Ulcer

Did the patient have a duodenal or gastric ulcer?*	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes and the <i>H. pylori</i> status was unknown, is there a plan documented for assessing <i>H. pylori</i> status? ^{CR}	<input type="checkbox"/> Yes <input type="checkbox"/> No

Barrett's Esophagus

Was there an endoscopic finding consistent with Barrett's esophagus?*	<input type="checkbox"/> No <input type="checkbox"/> Yes – Suspected <input type="checkbox"/> Yes – Previously Established
If yes, what was the length in centimeters of the circumferential and maximal extents of the Barrett's segment or the suspected Barrett's segment? ^{CR}	Circumferential Extent: _____ Maximal Extent: _____
How many specimen jars were sent to pathology? ^{CR}	
Was Barrett's esophagus confirmed by pathology on the current exam?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, was it dysplastic?	<input type="checkbox"/> Non-dysplastic <input type="checkbox"/> Indefinite for dysplasia <input type="checkbox"/> Low-grade dysplasia <input type="checkbox"/> High-grade dysplasia
Recommended endoscopic follow-up for surveillance of Barrett's esophagus:	<input type="checkbox"/> None <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months <input type="checkbox"/> 1 year <input type="checkbox"/> 1 and ½ years <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years <input type="checkbox"/> 5 years <input type="checkbox"/> Other(c) _____

Other Pathology

Was an esophageal carcinoma confirmed by pathology?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, check all that apply:	<input type="checkbox"/> Adenocarcinoma <input type="checkbox"/> Squamous cell carcinoma <input type="checkbox"/> Other malignancy

Adverse Events*



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Please specify immediate adverse events(s) occurring the same day, before the patient leaves the endoscopy facility

<input type="checkbox"/>	No Adverse Events
<input type="checkbox"/>	Bowel Perforation
<input type="checkbox"/>	Bleeding (Unplanned Intervention or Hospital Admission)
<input type="checkbox"/>	Emergency Dept visit related to EGD procedure
<input type="checkbox"/>	Hospital Admission related to EGD procedure
<input type="checkbox"/>	Sedation Related (Unplanned Intervention)
<input type="checkbox"/>	Death
<input type="checkbox"/>	Other, specify: _____

Unit Quality Indicators

Procedure End Time to Room Ready

Note: include all procedures done in a dedicated endoscopy procedure room. Examples of excluded procedures are: non-endoscopy OR, ED, patient rooms, ICU, radiology.

<p>Procedure End Time (24-hour clock):</p> <p><i>When all therapeutic and diagnostic interventions are completed (in many, but not all cases, this is when the endoscope is removed from the patient)</i></p>	<table border="1"> <tr> <td>m</td><td>m</td><td>d</td><td>d</td><td>y</td><td>y</td><td>y</td><td>y</td><td>H</td><td>H</td><td>M</td><td>M</td> </tr> </table>	m	m	d	d	y	y	y	y	H	H	M	M
m	m	d	d	y	y	y	y	H	H	M	M		
<p>Wheels Out Time (24-hour clock):</p>	<table border="1"> <tr> <td>m</td><td>m</td><td>d</td><td>d</td><td>y</td><td>y</td><td>y</td><td>y</td><td>H</td><td>H</td><td>M</td><td>M</td> </tr> </table>	m	m	d	d	y	y	y	y	H	H	M	M
m	m	d	d	y	y	y	y	H	H	M	M		
<p>Room Ready Time (24-hour clock):</p> <p><i>Room is cleaned and ready to accept another patient</i></p>	<table border="1"> <tr> <td>m</td><td>m</td><td>d</td><td>d</td><td>y</td><td>y</td><td>y</td><td>y</td><td>H</td><td>H</td><td>M</td><td>M</td> </tr> </table>	m	m	d	d	y	y	y	y	H	H	M	M
m	m	d	d	y	y	y	y	H	H	M	M		