



*EGD Data Collection Form*

**Patient Sociodemographic Information**

<b>Patient Type:</b>	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient		
<b>Patient Zip Code:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>Patient Birth Date:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>Patient Gender:</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Patient Height: (inches)	<input type="text"/> <input type="text"/>	Patient Weight: (pounds)	<input type="text"/> <input type="text"/> <input type="text"/>
<b>Patient Race:</b>	<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 <input type="checkbox"/> Medicaid <input type="checkbox"/> Tricare <input type="checkbox"/> None <input type="checkbox"/> Other (list specific name of plan if not listed above): _____		



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**Endoscopy Suite Information**

<b>Endoscopy Facility ID:</b>	<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	
<b>Physician ID:</b>	<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"/>	Did the Fellow Physician perform the procedure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Year of Fellowship	<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**

<b>Procedure Date:</b>	<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
<b>Endoscopy Procedure:</b>	<input type="checkbox"/> Colonoscopy <input type="checkbox"/> EGD <input type="checkbox"/> ERCP <input type="checkbox"/> EUS
<b>Current History &amp; Physical Documented on Chart?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Is <i>H. pylori</i> status known or unknown?</b>	<input type="checkbox"/> Known <input type="checkbox"/> Unknown
<b>Is the patient on anti-platelet or anticoagulation therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Informed Consent Documented in Medical Record?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>ASA Category:</b>	<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
<b>Sedation type:</b>	<input type="checkbox"/> None <input type="checkbox"/> Moderate <input type="checkbox"/> Deep (propofol) <input type="checkbox"/> General
<b>Sedation administered by:</b>	<input type="checkbox"/> Nurse <input type="checkbox"/> Endoscopist <input type="checkbox"/> Anesthesia professional



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**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.*

<b>Written <u>Discharge Instructions</u> provided to patient before discharge?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diet Instructions:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medication Resumption / Orders Given:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Return to Activities:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Potential Delayed Complications:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medical Emergency Contact Number:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Anticoagulation / Anti-platelet Therapy</b>	
<b>Anticoagulation / Anti-platelet Therapy: Patient given instructions relative to resumption of therapy</b>	<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 that persist despite an appropriate trial of therapy
<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 1. Suspected neoplastic lesion 2. Gastric or esophageal ulcer 3. Upper tract stricture or obstruction



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<input type="checkbox"/>	GI bleeding 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 intestinal metaplasia
<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"/>	Surveillance for malignancy in patients with premalignant conditions (e.g., Barrett's esophagus, polyposis syndromes, gastric adenomas, tylosis, or previous caustic ingestion).
<input type="checkbox"/>	Other, specify: _____



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**Placement of Percutaneous Enteral Feeding Tube**

- |  |  |
|--|--|
| Was a percutaneous enteral feeding tube placed?                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did the patient receive antibiotic therapy in the 24 hours before the procedure? | <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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did the patient receive endoscopic hemostatic therapy by any modality?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was there a finding of esophageal varices AND EITHER active bleeding OR stigmata of recent hemorrhage?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did the patient undergo esophageal variceal band ligation?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**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? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**Barrett's Esophagus**

- |  |  |
|--|--|
| Was the indication for the procedure Barrett's esophagus screening or surveillance, or was there an endoscopic finding of Barrett's? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If yes, what was the length in centimeter of the Barrett's segment?  |  |
| How many specimen jars were sent to pathology?   |  |

**Pathology**

- |   |  |
|---|--|
| Was Barrett's esophagus confirmed by pathology? | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| If yes, was it dysplastic?                      | <input type="checkbox"/> Non-dysplastic<br><input type="checkbox"/> Indefinite for dysplasia<br><input type="checkbox"/> Low-grade dysplasia<br><input type="checkbox"/> High-grade dysplasia  |
| Recommended endoscopic follow-up:               | <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months <input type="checkbox"/> 1 year<br><input type="checkbox"/> 1 and ½ years <input type="checkbox"/> 2 years <input type="checkbox"/> 3 years <input type="checkbox"/> 4 years<br><input type="checkbox"/> 5 years <input type="checkbox"/> Other(c) _____ |



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**Adverse Events**

**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: _____