SGO COR Clinical Outcomes Registry

CERVICAL CANCER OPERATIVE CARE AND POSTOP COMPLICATIONS WITHIN 30 DAYS

Data Collection Form

July 2021

I. PATIENT DEMOGRAPHICS

Medical Record Number	Date of Birth	Zip Code

Race (select all applicable)				
	○ White/Caucasian	○ Asian	○ Native Hawaiian/Pacific Islander	○ Unknown
	○ African American	○ American Indian/Alaskan Native	○ Hispanic/Latino/Spanish	○ Chose Not to Disclose

II. CERVICAL CANCER SCREENING

Date of screening _____ Is patient U.S. born: ○ Yes ○ No ○ Unknown

Has patient seen a healthcare provider in the past 5 years? ○ Yes ○ No Has patient ever had a pregnancy? ○ Yes ○ No

How many pregnancies has the patient had altogether? (include all pregnancies including those ending in live birth, miscarriage, abortion, still birth, and ectopic pregnancies.) _____

Date of most recent pregnancy: _____

Did a pregnancy delay disease management? ○ Yes ○ No

Has patient had a Pap test in the past 5 years? ○ Yes ○ No (If yes, please complete table below for all Pap results in the past 5 years)

Date of Pap	Type of Pap	Lab where run? (Name)	Image-based evaluation?	Performed by	Satisfactory test result?	Endocervical/ TZ component present?	Pap result	Was patient referred to colposcopy?	Date of colposcopy	Was colposcopy satisfactory?	Treated for an abnormal PAP or cervical biopsy in the past 5 years?	Date of abnormal PAP or cervical biopsy treatment	Type of treatment received	Performed by
__/__/ MM/DD/YEAR	○ STM/ Glass slide ○ ThinPrep ○ SurePath		○ Yes ○ No ○ Not indicated	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)	○ Yes ○ No ○ Not indicated	○ Yes ○ No ○ Not indicated	○ Normal (NILM) ○ ASC-US ○ LSIL ○ HSIL ○ AGC ○ AIS	○ Yes ○ No ○ Not indicated	__/__/ MM/DD/YEAR	○ Yes ○ No ○ Not reported	○ Yes ○ No	__/__/ MM/DD/YEAR	○ LEEP ○ Cold knife cone ○ CO2 Laser therapy ○ Cryo	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)
__/__/ MM/DD/YEAR	○ STM/ Glass slide ○ ThinPrep ○ SurePath		○ Yes ○ No ○ Not indicated	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)	○ Yes ○ No ○ Not indicated	○ Yes ○ No ○ Not indicated	○ Normal (NILM) ○ ASC-US ○ LSIL ○ HSIL ○ AGC ○ AIS	○ Yes ○ No ○ Not indicated	__/__/ MM/DD/YEAR	○ Yes ○ No ○ Not reported	○ Yes ○ No	__/__/ MM/DD/YEAR	○ LEEP ○ Cold knife cone ○ CO2 Laser therapy ○ Cryo	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)
__/__/ MM/DD/YEAR	○ STM/ Glass slide ○ ThinPrep ○ SurePath		○ Yes ○ No ○ Not indicated	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)	○ Yes ○ No ○ Not indicated	○ Yes ○ No ○ Not indicated	○ Normal (NILM) ○ ASC-US ○ LSIL ○ HSIL ○ AGC ○ AIS	○ Yes ○ No ○ Not indicated	__/__/ MM/DD/YEAR	○ Yes ○ No ○ Not reported	○ Yes ○ No	__/__/ MM/DD/YEAR	○ LEEP ○ Cold knife cone ○ CO2 Laser therapy ○ Cryo	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)
__/__/ MM/DD/YEAR	○ STM/ Glass slide ○ ThinPrep ○ SurePath		○ Yes ○ No ○ Not indicated	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)	○ Yes ○ No ○ Not indicated	○ Yes ○ No ○ Not indicated	○ Normal (NILM) ○ ASC-US ○ LSIL ○ HSIL ○ AGC ○ AIS	○ Yes ○ No ○ Not indicated	__/__/ MM/DD/YEAR	○ Yes ○ No ○ Not reported	○ Yes ○ No	__/__/ MM/DD/YEAR	○ LEEP ○ Cold knife cone ○ CO2 Laser therapy ○ Cryo	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)

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Has patient had an HPV in the past 5 years? ◯ Yes ◯ No (If yes, please complete table below for all HPV results in the past 5 years)

Date of HPV	Type of HPV	Lab where run? (Name)	HPV result	HPV genotyping performed?	Results of genotyping?	Performed by	Was patient referred to colposcopy?	Date of colposcopy	Was colposcopy satisfactory?
__/__/_ MM/DD/YEAR	◯ Qiagen ◯ Cervista ◯ Roche Cobas ◯ Aptima ◯ Laboratory Developed Test (LDT) ◯ Not Specified		◯ Positive HR ◯ Negative HR ◯ Indeterminate ◯ Not Reported	◯ HPV 16 ◯ HPV 18 ◯ HPV 45	◯ Positive ◯ Negative ◯ Not Reported	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____	◯ Yes ◯ No ◯ Not indicated	__/__/ MM/DD/YEAR	◯ Yes ◯ No ◯ Not reported
__/__/_ MM/DD/YEAR	◯ Qiagen ◯ Cervista ◯ Roche Cobas ◯ Aptima ◯ Laboratory Developed Test (LDT) ◯ Not Specified		◯ Positive HR ◯ Negative HR ◯ Indeterminate ◯ Not Reported	◯ HPV 16 ◯ HPV 18 ◯ HPV 45	◯ Positive ◯ Negative ◯ Not Reported	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____	◯ Yes ◯ No ◯ Not indicated	__/__/ MM/DD/YEAR	◯ Yes ◯ No ◯ Not reported
__/__/_ MM/DD/YEAR	◯ Qiagen ◯ Cervista ◯ Roche Cobas ◯ Aptima ◯ Laboratory Developed Test (LDT) ◯ Not Specified		◯ Positive HR ◯ Negative HR ◯ Indeterminate ◯ Not Reported	◯ HPV 16 ◯ HPV 18 ◯ HPV 45	◯ Positive ◯ Negative ◯ Not Reported	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____	◯ Yes ◯ No ◯ Not indicated	__/__/ MM/DD/YEAR	◯ Yes ◯ No ◯ Not reported
__/__/_ MM/DD/YEAR	◯ Qiagen ◯ Cervista ◯ Roche Cobas ◯ Aptima ◯ Laboratory Developed Test (LDT) ◯ Not Specified		◯ Positive HR ◯ Negative HR ◯ Indeterminate ◯ Not Reported	◯ HPV 16 ◯ HPV 18 ◯ HPV 45	◯ Positive ◯ Negative ◯ Not Reported	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____	◯ Yes ◯ No ◯ Not indicated	__/__/ MM/DD/YEAR	◯ Yes ◯ No ◯ Not reported

Please complete table below for all results in the past 5 years

Has patient had a uterus biopsy performed? ◯ Yes ◯ No
Has patient had a vulva biopsy performed? ◯ Yes ◯ No
Has patient had a cervical biopsy performed? ◯ Yes ◯ No
Has patient had an anus biopsy performed? ◯ Yes ◯ No
Has patient had a vagina biopsy performed? ◯ Yes ◯ No
Complete all applicable tables.

UTERUS

Date of uterus biopsy test	Uterus biopsy test results	Performed by
__/__/__ MM/DD/YEAR	◯ Normal ◯ AGUS ◯ Hyperplasia without atypia ◯ Hyperplasia with atypia ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____
__/__/__ MM/DD/YEAR	◯ Normal ◯ AGUS ◯ Hyperplasia without atypia ◯ Hyperplasia with atypia ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____
__/__/__ MM/DD/YEAR	◯ Normal ◯ AGUS ◯ Hyperplasia without atypia ◯ Hyperplasia with atypia ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____
__/__/__ MM/DD/YEAR	◯ Normal ◯ AGUS ◯ Hyperplasia without atypia ◯ Hyperplasia with atypia ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____

ANUS

Date of Anus biopsy test	Anus biopsy test results	Performed by
MM/DD/YEAR	○ Normal ○ Dysplasia – mild ○ Dysplasia - moderate ○ Dysplasia - severe ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
MM/DD/YEAR	○ Normal ○ Dysplasia – mild ○ Dysplasia - moderate ○ Dysplasia - severe ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
MM/DD/YEAR	○ Normal ○ Dysplasia – mild ○ Dysplasia - moderate ○ Dysplasia - severe ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
MM/DD/YEAR	○ Normal ○ Dysplasia – mild ○ Dysplasia - moderate ○ Dysplasia - severe ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____

VULVA

Date of Vulva biopsy test	Vulva biopsy test results	Performed by
MM/DD/YEAR	○ Normal ○ VIN-1 ○ VIN-2 ○ VIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
MM/DD/YEAR	○ Normal ○ VIN-1 ○ VIN-2 ○ VIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
MM/DD/YEAR	○ Normal ○ VIN-1 ○ VIN-2 ○ VIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
MM/DD/YEAR	○ Normal ○ VIN-1 ○ VIN-2 ○ VIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____

VAGINA

Date of Vagina biopsy test	Vagina biopsy test results	Performed by
___/___/___ MM/DD/YEAR	○ Normal ○ AGUS ○ VAIN-1 ○ VAIN-2 ○ VAIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
___/___/___ MM/DD/YEAR	○ Normal ○ AGUS ○ VAIN-1 ○ VAIN-2 ○ VAIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
___/___/___ MM/DD/YEAR	○ Normal ○ AGUS ○ VAIN-1 ○ VAIN-2 ○ VAIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
___/___/___ MM/DD/YEAR	○ Normal ○ AGUS ○ VAIN-1 ○ VAIN-2 ○ VAIN-3 ○ Cancer	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____

CERVICAL

Date of Cervical biopsy test	Cervical biopsy test results	Performed by
___/___/___ MM/DD/YEAR	○ CIN-1 ○ CIN-2 ○ CIN-3 ○ CGIN/Atypical glandular cells ○ LSIL ○ HSIL	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
___/___/___ MM/DD/YEAR	○ CIN-1 ○ CIN-2 ○ CIN-3 ○ CGIN/Atypical glandular cells ○ LSIL ○ HSIL	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
___/___/___ MM/DD/YEAR	○ CIN-1 ○ CIN-2 ○ CIN-3 ○ CGIN/Atypical glandular cells ○ LSIL ○ HSIL	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____
___/___/___ MM/DD/YEAR	○ CIN-1 ○ CIN-2 ○ CIN-3 ○ CGIN/Atypical glandular cells ○ LSIL ○ HSIL	○ Family practice ○ Primary care physician ○ Gynecologist ○ Gyn/onc ○ Advanced Practice Clinician (APN,PA, NP) ○ Other (specify)_____

Has patient had a Endocervical Curettage (ECC) in the past 5 years? ◯ Yes ◯ No (If yes, please complete table below for all results in the past 5 years)

ENDOCERVICAL CURETTAGE (ECC)

Date of Endocervical Curettage (ECC) test	Endocervical Curettage (ECC) test results	Performed by
MM/DD/YEAR	◯ Normal ◯ Inadequate ◯ AIS ◯ CGIN/Atypical glandular cells ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____
MM/DD/YEAR	◯ Normal ◯ Inadequate ◯ AIS ◯ CGIN/Atypical glandular cells ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____
MM/DD/YEAR	◯ Normal ◯ Inadequate ◯ AIS ◯ CGIN/Atypical glandular cells ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____
MM/DD/YEAR	◯ Normal ◯ Inadequate ◯ AIS ◯ CGIN/Atypical glandular cells ◯ Cancer	◯ Family practice ◯ Primary care physician ◯ Gynecologist ◯ Gyn/onc ◯ Advanced Practice Clinician (APN,PA, NP) ◯ Other (specify)_____

Has patient taken any immunosuppressant medications within the past 5 years?	◯ Yes ◯ No
Has patient taken any anti-retrovirals medications within the past 5 years?	◯ Yes ◯ No

Has patient experienced symptoms of cervical disease within the past 5 years?	◯ Yes ◯ No	If yes to symptoms, please select all that apply.	◯ Abnormal bleeding ◯ Bleeding after intercourse ◯ Discharge ◯ Pain ◯ Urinary symptoms) ◯ Other (specify)_____

II. HOSPITALIZATION

Hospital Admit Date	Hospital Discharge Date

III. PREOPERATIVE RISK FACTORS

Height (cm)/(in)	Weight (kg)/(lb)	Body Mass Index (Calculated field)	ASA Class (time of surgery) ◯1 ◯2 ◯3 ◯4
Diabetes: ◯ Yes ◯ No	If Yes, Select Medication: ◯ None ◯ Insulin ◯ Oral Hypoglycemic		
Current Smoker (within one year of surgery): ◯ Yes ◯ No			
Prior Abdominal Surgery: ◯ Yes ◯ No Year:_____			

History of Conditions/Previous Interventions (select all applicable):

Cardiac Surgery (includes: stent, CABG, Valve, Pacemaker, Other Cardiac Surgery): ◯ Yes ◯ No			
Creatinine level >1.5: ◯ Yes ◯ No	Steroid Use (Use of oral/parenteral steroids for >10 days in prior 30 days): ◯ Yes ◯ No		
Pulmonary: ◯ Yes ◯ No	◯ COPD	◯ Pulmonary HTN	◯ Other
Heme: ◯ Yes ◯ No	◯ DVT/PE (within 90 days)	◯ Transfusion	◯ Other
Neuro: ◯ Yes ◯ No	◯ Stroke	◯ Other	
Endocrine: ◯ Yes ◯ No	◯ Thyroid Hyper	◯ Thyroid Hypo	
Cardiac Conditions: ◯ Yes ◯ No	◯ Afib/Arrhythmia ◯ HTN	◯ Angina (within 30 days) ◯ MI (within 6 months)	◯ CHF (within 30 days) ◯ Other
Presurgical Radiotherapy: ◯ Yes ◯ No			

Neoadjuvant Therapy: ◯ Yes ◯ No	Neoadjuvant Therapy start date_____
Which neoadjuvant chemotherapy drugs were used? _____	
Neoadjuvant therapy cycles_____	Did patient undergo surgery?: ◯ Yes ◯ No

IV. HISTOLOGY

◯ Squamous Cell Carcinoma	◯ Adenocarcinoma	◯ Adenosquamos	◯ Glassy Cell	◯ Neuroendocrine	◯ Clear Cell:	◯ Other:
Largest Primary Tumor Diameter (cm)			Lymphovascular Space Invasion: ◯ Yes ◯ No ◯ Unknown			

V. SURGICAL PATHOLOGY

FIGO Stage: ◯ IA ◯ IA1 ◯ IA2 ◯ IB ◯ IB1 ◯ IB2 ◯ IIA ◯ IIA1 ◯ IIA2 ◯ IIB ◯ IIIA ◯ IIIB ◯ IVA ◯ IVB ◯ Recurrent

Pelvic Lymphadenectomy: ◯ Yes ◯ No If Yes, Provide Information	Number of Right Nodes Removed	Number of Left Nodes Removed	TOTALS (calculated field)
	Number of Right Nodes Positive	Number of Left Nodes Positive	TOTALS (calculated field)
Paraaortic Lymphadenectomy: ◯ Yes ◯ No If Yes, Provide Information	Total Number Removed	Total Number Positive	
Sentinel Lymph Node: ◯ Yes ◯ No If Yes, Provide Information:	Positive: ◯ Yes ◯ No	If SLN positive, was Ultra Staging Performed? ◯ Yes ◯ No If Yes, Select:	H & E Positive: ◯ Yes ◯ No Microstaged Positive: ◯ Yes ◯ No Isolated (ITC) Positive: ◯ Yes ◯ No Micromets Positive: ◯ Yes ◯ No Macromets Positive: ◯ Yes ◯ No

Was chemosensitivity assay ordered: ◯ Yes ◯ No

VI. SURGERY

National Provider Identifier:		Date of Surgery:	
Surgeon Specialty:	◯ Gynecologic Oncology ◯ Obstetrics and Gynecology ◯ General Surgery ◯ Other		
Surgical Approach:	◯ Laparotomy ◯ Conventional Laparoscopy ◯ Robotic-assisted		
Did patient convert to Laparotomy: ◯ Yes ◯ No		If Yes: ◯ Large BMI ◯ Extension Adhesion ◯ Other_____ ◯ Large Uterus ◯ Anesthesia or Insufflation Related Problems	
Extent of Cancer: (if stage IV):	◯ N/A ◯ Diaphragm ◯ Below Pelvic Brim ◯ Carcinomatosis (>50% of all peritoneal surfaces involved by tumor)	◯ Spleen ◯ Liver ◯ Lung	◯ Small Bowel Serosa/Mensentery ◯ Other
Previous hysterectomy: ◯ Yes ◯ No	If yes, date:_____(only year needed)		
Operation:	◯ Hysterectomy Type I (extrafascial) ◯ Exenteration (Total/Anterior/ Posterior) ◯ Radical Trachelectomy	◯ Hysterectomy Type II (modified radical) ◯ Cold Knife Cone/LEEP ◯ Biopsy only	◯ Hysterectomy Type III (radical) ◯ Other
Uterine weight (in grams):	_____		
Operative Note Completed/Present (within 48 hours of Operation) ◯ Yes ◯ No	If patient undergoes radical surgery, Select: ◯ Positive lymph nodes	◯ Positive parametria	◯ Positive vaginal margin
Estimated Blood Loss (ml)			

OR Entry Time:_____(24 hr. clock)

Skin Incision Start Time:_____(24 hr. clock)

Skin Incision Stop Time:_____(24 hr. clock)

OR Exit Time:_____(24 hr. clock)

VII. POSTOPERATIVE COMPLICATIONS WITHIN 30 DAYS

Patient Medical Record Number			Date of Birth	Zip Code
Postoperative Complication: ◯ Yes ◯ No		Date of Occurrence	Unplanned ICU transfer or admission: ◯ Yes ◯ No	
Grade 2 Complication: ◯ Yes ◯ No (select all applicable)	◯ Wound Infection Requiring Antibiotics ◯ Blood Transfusion ◯ Lymphatic	◯ UTI ◯ Total Parenteral Nutrition	◯ Pneumonia ◯ DVT	◯ Other Condition Requiring Antibiotics ◯ PE
Grade 3 Complication: ◯ Yes ◯ No (select all applicable)	Return to OR	◯ Bowel Perforation or Obstruction ◯ Bleeding ◯ Abdominal Abscess	◯ Wound Disruption ◯ Fistula ◯ Cuff Dehiscence	◯ Other
	Endoscopic Procedures	◯ PEG ◯ Colonoscopy	◯ Laparoscopy ◯ Other	◯ Upper Endoscopy
	Interventional Radiology	◯ Ureteral Stent Placement	◯ Colonic Stent	◯ Other:
	Organ Failure	◯ Cardiac ◯ GI/Hepatic	◯ CNS ◯ Renal	◯ Hematologic ◯ Respiratory
Grade 4 Complication: Postoperative Complication-Related Death: ◯ Yes ◯ No			Date of Death	