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## Lapco GAS Form - for cases not submitted to NBOCAP or Benign Cases

## PATIENT

P1 Patient NHS number	P2 Initials	P3 DOB mm <input type="text"/> dd <input type="text"/> yyyy <input type="text"/>	P4 Gender <input type="radio"/> male <input type="radio"/> female
P5 Operating date mm <input type="text"/> dd <input type="text"/> yyyy <input type="text"/>	P6 Height cm	P7 Weight kg	P8 ASA Grade <input type="radio"/> I <input type="radio"/> II <input type="radio"/> III <input type="radio"/> IV <input type="radio"/> V <input type="radio"/> Not Known

## DIAGNOSIS

D1 Diagnosis

Benign polyps  Cancer  IBD  Diverticulitis  Other - Specify

## RESECTION

H1 Resection

R/hemi  Transverse Colectomy  L/hemi  Sigmoid Colectomy  Hartmann  Anterior Resection  APER  
 Panproctocolectomy  Total Colectomy  Subtotal Colectomy  Other - specify

## SURGICAL ACCESS

S1 Open/Laparoscopic <input type="radio"/> Open <input type="radio"/> Laparoscopic <input type="radio"/> Laparoscopic converted to open	S2 Reason for conversion <input type="checkbox"/> N/A <input type="checkbox"/> Equipment problems <input type="checkbox"/> Bleeding <input type="checkbox"/> Exposure/Anatomy <input type="checkbox"/> Bowel perforation
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## OPERATION

O1  
This is my  th laparoscopic resection ( if known / applicable )

O2 Urgency <input type="radio"/> Elective <input type="radio"/> Scheduled <input type="radio"/> Urgent <input type="radio"/> Emergency <input type="radio"/> Not Known	O3 Prior abdominal surgery <input type="radio"/> Yes <input type="radio"/> No	O4 Stoma <input type="radio"/> Ileostomy <input type="radio"/> Colostomy <input type="radio"/> None
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## PATHOLOGICAL STATE ( For Cancer only )

PA1 Pathology		
T-stage <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4	N-stage <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3	M-stage <input type="radio"/> 0 <input type="radio"/> 1

## COMPLICATIONS

C1 Intra-operative Complication <input type="checkbox"/> None <input type="checkbox"/> Surgical emphysema <input type="checkbox"/> Pulmonary insufficiency <input type="checkbox"/> Bleeding/hematoma <input type="checkbox"/> Duodenal injury <input type="checkbox"/> Small bowel injury <input type="checkbox"/> Ureteric injury <input type="checkbox"/> Major vessel injury <input type="checkbox"/> Gross faecal contamination <input type="checkbox"/> Bladder injury <input type="checkbox"/> Injury by trocar <input type="checkbox"/> Other - specify 	
C2 Surgical Post-operative Complication <input type="checkbox"/> None <input type="checkbox"/> Leak <input type="checkbox"/> Abscess/wound infection <input type="checkbox"/> Bleed <input type="checkbox"/> Obstruction <input type="checkbox"/> Ileus <input type="checkbox"/> Stoma complication <input type="checkbox"/> Other - specify 	
C3 Medical complication <input type="checkbox"/> None <input type="checkbox"/> Chest infection <input type="checkbox"/> UTI <input type="checkbox"/> Cardiac event <input type="checkbox"/> Stroke <input type="checkbox"/> Other - specify 	C4 Reoperation <input type="radio"/> Yes <input type="radio"/> No

## HOSPITAL STAY

E1 Readmission to hospital <input type="radio"/> Yes <input type="radio"/> No	E2 Hospital stay _____ days	E3 Intrahospital death <input type="radio"/> Yes <input type="radio"/> No	Date of death mm <input type="text"/> dd <input type="text"/> yyyy <input type="text"/>
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