St. Jude Children's Research Hospital

Department of Epidemiology
Mail Stop 735
262 Danny Thomas Place
Memphis, TN 38105-3678

Childhood Cancer Survivor Study
Additional Treatment Period

Medical Record Abstraction Worksheet ADDENDUM 2008

Name of Patient: _____
(Please print)

Institutional Patient Identification Number: _____

Date of Initial Diagnosis: M M / D D / Y Y Y Y

Primary Diagnosis: _____

Person Completing this Worksheet: _____
(Please print)

Institutional Password:

CCSS ID#:

Today's Date: M M / D D / Y Y Y Y

This Medical Record Abstraction Worksheet ADDENDUM is ____ **of** ____ **total abstraction worksheets.**

The Medical Record Abstraction Worksheet ADDENDUM contains a single "treatment collection" section.

In this treatment collection section, please record chemotherapy, surgery and radiotherapy received by this patient. In the event there was a period of six months or more where the patient did not receive any treatment, you will be asked to provide any subsequent treatment periods on the Medical Record Abstraction Worksheet ADDENDUM (2nd treatment, 3rd treatment, 4th treatment). The definition of a "treatment period" is continuous therapy with no gap in therapy (chemotherapy, radiation, or surgery) greater than six months.

Is this treatment for the initial treatment period?

- ☐ No
- ☐ Yes → *If yes, do not use this worksheet. Please use Medical Record Abstraction Worksheet.*

Is this treatment information for the occurrence of:

- ☐ Persistence/Progression of Primary Disease
- ☐ First Recurrence
- ☐ Second Recurrence
- ☐ Third Recurrence
- ☐ First New Malignancy
- ☐ Second New Malignancy
- ☐ Third New Malignancy
- ☐ Other

Specify

Date of Occurrence:

M M / D D / Y Y Y Y

Has the patient had a gap in therapy of greater than 6 months?

- ☐ No
- ☐ Yes

If yes, complete one Medical Record Abstraction Worksheet ADDENDUM for each additional treatment period.

Continue on next page.

A. BONE MARROW TRANSPLANT

1. **Has this patient received a hematopoietic stem cell infusion during this treatment period?**

   ☐ Yes

   ☐ No → *Go to Protocol Information section B.*

2. **What was the donor source(s) of this infusion?**
   (Check all that apply)

   ☐ Allogeneic related marrow

   ☐ Allogeneic unrelated marrow

   ☐ Autologous marrow (marrow harvest)

   ☐ Autologous stem cells (pheresis)

   ☐ Cord blood

3. **Date of first hematopoietic stem cell infusion:**
   (Please report date of the first infusion if multiple infusions were received.)

   M M / D D / Y Y Y Y

B. PROTOCOL INFORMATION

Indicate all standard protocols this patient was placed on during this treatment period.

Protocol 1	Protocol 2	Protocol 3
Study Group *(Select only one)*	**Study Group** *(Select only one)*	**Study Group** *(Select only one)*
☐ CCG ☐ St. Jude	☐ CCG ☐ St. Jude	☐ CCG ☐ St. Jude
☐ POG ☐ None	☐ POG ☐ None	☐ POG ☐ None
☐ SWOG ☐ Other	☐ SWOG ☐ Other	☐ SWOG ☐ Other
☐ CALGB *Specify group*	☐ CALGB *Specify group*	☐ CALGB *Specify group*
Protocol #	**Protocol #**	**Protocol #**

C. CHEMOTHERAPY

Any gap in therapy of greater than 6 months will require a separate treatment section found in the Medical Record Abstraction Worksheet ADDENDUM.

1. **Did this individual receive any chemotherapy during this treatment period?**

   ☐ Yes

   ☐ No → *Go to Surgical Procedures section D, page 9.*

2. **Date first chemotherapy initiated:**

   M M / D D / Y Y Y Y

3. **Date all chemotherapy completed:**

   M M / D D / Y Y Y Y

Chemotherapy information (exposure)

Please check all chemotherapies received and route of administration where indicated.

- Actinomycin-D ☐
- Anti-Thymocyte Globulin (ATG) ☐
- Ara-G (Nelarabine) ☐
- 5-Azacytadine ☐
- BCNU (Carmustine) ☐
- Bleomycin ☐
  - If yes, specify route. ☐ IV/IM ☐ Sub-Q
- Busulfan ☐
  - If yes, specify route. ☐ IV/IM ☐ PO
- Campath (Alemtuzumab) ☐
- Carboplatin ☐
- CCNU (Lomustine) ☐
- Chlorambucil ☐
- Cis-platinum ☐
- Cyclophosphamide (Cytoxan) ☐
  - If yes, specify route. ☐ IV/IM ☐ PO
- Cyclosporine (CSA) ☐
- Cytosine arabinoside (Ara-C) ☐
- Daunorubicin (Daunomycin) ☐
- Dexamethasone ☐
- Doxil ☐
- Doxorubicin (Adriamycin) ☐
- DTIC (Dacarbazine) ☐
- Epirubicin ☐
- Erythropoetin (EPO) ☐
- Fludarabine ☐
- 5-FU (Fluorouracil) ☐
- G-CSF (Filgrastim) ☐
- Gemcitabine (Gemzar) ☐
- Gleevec (Imatinib mesylate) ☐
- GM-CSF (Sargramostim) ☐
- Hydroxyurea (Hydrea) ☐
- Idarubicin ☐
- Ifosfamide ☐
- Interferon ☐
- Interleukin-2 (Aldesleukin) ☐
- Irinotecan (Camptosar) ☐
- L-Asparaginase ☐
- Melphalan ☐
  - If yes, specify route. ☐ IV/IM ☐ PO
- 6-Mercaptopurine (6-MP) ☐
- Mesna ☐
- Methotrexate ☐
  - If yes, specify route. ☐ IV ☐ IM ☐ PO ☐ IT/Ommaya
- Mitoxantrone (Novantrone) ☐
- Mycophenolate (CellCept) ☐
- Mylotarg (Gemtuzumab) ☐
- Nitrogen mustard (Mechlorethamine) ☐
- Prednisone ☐
- Procarbazine ☐
- Retinoic Acid ☐
- Rituximab (Rituxan) ☐
- Sirolimus ☐
- Tacrolimus ☐
- Taxol ☐
- Taxotere ☐
- Temozolomide (Temodar) ☐
- 6-Thioguanine (6-TG) ☐
- Thiotepa ☐
  - If yes, specify route. ☐ IV/IM ☐ IT
- Topotecan (Hycamtin) ☐
- Vinblastine (Velban) ☐
- Vincristine ☐
- Vinorelbine (Navelbine) ☐
- VM-26 (Teniposide) ☐
- VP-16 (Etoposide) ☐
  - If yes, specify route. ☐ IV/IM ☐ PO
- Zinecard (Dexrazoxane) ☐
- Other drug 1 ☐
  - ***Specify***
- Other drug 2 ☐
  - ***Specify***
- Other drug 3 ☐
  - ***Specify***
- Other drug 4 ☐
  - ***Specify***
- Other drug 5 ☐
  - ***Specify***

Specific Agents

Use the following codes for abstracting cumulative dose for selected drugs.

Codes for Specific Agents:

1 BCNU (Carmustine) IV/IM	13 Doxil IV/IM	25 Nitrogen mustard (Mechlorethamine) IV/IM
2 Bleomycin IV/IM	14 Doxorubicin (Adriamycin) IV/IM	26 Procarbazine PO
3 Bleomycin Sub-Q	15 DTIC (Dacarbazine) IV/IM	27 Temozolomide (Temodar) PO
4 Busulfan IV/IM	16 Epirubicin IV/IM	28 Thiotepa IV/IM
5 Busulfan PO	17 Idarubicin IV/IM	29 Thiotepa IT
6 Carboplatin IV/IM	18 Ifosfamide IV/IM	30 Vincristine IV/IM
7 CCNU (Lomustine) PO	19 Melphalan IV/IM	31 VM-26 (Teniposide) IV/IM
8 Chlorambucil PO	20 Melphalan PO	32 VP-16 (Etoposide) IV/IM
9 Cis-platinum IV/IM	21 Methotrexate IV	33 VP-16 (Etoposide) PO
10 Cyclophosphamide (Cytoxan) IV/IM	22 Methotrexate IM	34 Zinecard (Dexrazoxane) IV/IM
11 Cyclophosphamide (Cytoxan) PO	23 Methotrexate IT/Ommaya	
12 Daunorubicin (Daunomycin) IV/IM	24 Mitoxantrone (Novantrone) IV/IM	

For the agents listed above, please supply the following information:

Note: The web-based abstraction will only prompt you for a single start date, stop date, BSA, etc., per drug. If multiple routes for a single drug are used, please use the earliest start date and the latest stop date for your web-based entry. Please enter BSA, weight, and height at the time of earliest start date for the drug.

1. Drug # ☐☐

Specify:

- ☐ Total dose abstracted
- ☐ Total dose, some estimated
- ☐ Incomplete or Partial dose
- ☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose ☐☐☐☐☐

Indicate Dosage

- ☐ microgram ☐ gram
- ☐ milligram ☐ International Units

Body Surface Area ☐.☐☐

Weight (kg) ☐☐☐.☐

Height (cm) ☐☐☐.☐☐

2. Drug # ☐☐

Specify:

- ☐ Total dose abstracted
- ☐ Total dose, some estimated
- ☐ Incomplete or Partial dose
- ☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose ☐☐☐☐☐

Indicate Dosage

- ☐ microgram ☐ gram
- ☐ milligram ☐ International Units

Body Surface Area ☐.☐☐

Weight (kg) ☐☐☐.☐

Height (cm) ☐☐☐.☐☐

Specific Agents

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2 Bleomycin IV/IM	14 Doxorubicin (Adriamycin) IV/IM	26 Procarbazine PO
3 Bleomycin Sub-Q	15 DTIC (Dacarbazine) IV/IM	27 Temozolomide (Temodar) PO
4 Busulfan IV/IM	16 Epirubicin IV/IM	28 Thiotepa IV/IM
5 Busulfan PO	17 Idarubicin IV/IM	29 Thiotepa IT
6 Carboplatin IV/IM	18 Ifosfamide IV/IM	30 Vincristine IV/IM
7 CCNU (Lomustine) PO	19 Melphalan IV/IM	31 VM-26 (Teniposide) IV/IM
8 Chlorambucil PO	20 Melphalan PO	32 VP-16 (Etoposide) IV/IM
9 Cis-platinum IV/IM	21 Methotrexate IV	33 VP-16 (Etoposide) PO
10 Cyclophosphamide (Cytoxan) IV/IM	22 Methotrexate IM	34 Zinecard (Dexrazoxane) IV/IM
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3. Drug # ☐☐

Specify:

☐ Total dose abstracted
☐ Total dose, some estimated
☐ Incomplete or Partial dose
☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose ☐☐☐☐☐

Indicate Dosage
☐ microgram ☐ gram
☐ milligram ☐ International Units

Body Surface Area ☐.☐☐

Weight (kg) ☐☐☐.☐

Height (cm) ☐☐☐.☐☐

4. Drug # ☐☐

Specify:

☐ Total dose abstracted
☐ Total dose, some estimated
☐ Incomplete or Partial dose
☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose ☐☐☐☐☐

Indicate Dosage
☐ microgram ☐ gram
☐ milligram ☐ International Units

Body Surface Area ☐.☐☐

Weight (kg) ☐☐☐.☐

Height (cm) ☐☐☐.☐☐

5. Drug #

Specify:

☐ Total dose abstracted
☐ Total dose, some estimated
☐ Incomplete or Partial dose
☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose

Indicate Dosage
☐ microgram ☐ gram
☐ milligram ☐ International Units

Body Surface Area .

Weight (kg) .

Height (cm) .

6. Drug #

Specify:

☐ Total dose abstracted
☐ Total dose, some estimated
☐ Incomplete or Partial dose
☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose

Indicate Dosage
☐ microgram ☐ gram
☐ milligram ☐ International Units

Body Surface Area .

Weight (kg) .

Height (cm) .

7. Drug #

Specify:

☐ Total dose abstracted
☐ Total dose, some estimated
☐ Incomplete or Partial dose
☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose

Indicate Dosage
☐ microgram ☐ gram
☐ milligram ☐ International Units

Body Surface Area .

Weight (kg) .

Height (cm) .

8. Drug #

Specify:

☐ Total dose abstracted
☐ Total dose, some estimated
☐ Incomplete or Partial dose
☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose

Indicate Dosage
☐ microgram ☐ gram
☐ milligram ☐ International Units

Body Surface Area .

Weight (kg) .

Height (cm) .

Use the following codes for abstracting cumulative dose for selected drugs.

Codes for Specific Agents:

1 BCNU (Carmustine) IV/IM	13 Doxil IV/IM	25 Nitrogen mustard (Mechlorethamine) IV/IM
2 Bleomycin IV/IM	14 Doxorubicin (Adriamycin) IV/IM	26 Procarbazine PO
3 Bleomycin-Sub Q	15 DTIC (Dacarbazine) IV/IM	27 Temozolomide (Temodar) PO
4 Busulfan IV/IM	16 Epirubicin IV/IM	28 Thiotepa IV/IM
5 Busulfan PO	17 Idarubicin IV/IM	29 Thiotepa IT
6 Carboplatin IV/IM	18 Ifosfamide IV/IM	30 Vincristine IV/IM
7 CCNU (Lomustine) PO	19 Melphalan IV/IM	31 VM-26 (Teniposide) IV/IM
8 Chlorambucil PO	20 Melphalan PO	32 VP-16 (Etoposide) IV/IM
9 Cis-platinum IV/IM	21 Methotrexate IV	33 VP-16 (Etoposide) PO
10 Cyclophosphamide (Cytoxan) IV/IM	22 Methotrexate IM	34 Zinecard (Dexrazoxane) IV/IM
11 Cyclophosphamide (Cytoxan) PO	23 Methotrexate IT/Ommaya	
12 Daunorubicin (Daunomycin) IV/IM	24 Mitoxantrone (Novantrone) IV/IM	

For the agents listed above, please supply the following information:

Note: The web-based abstraction will only prompt you for a single start date, stop date, BSA, etc., per drug. If multiple routes for a single drug are used, please use the earliest start date and the latest stop date for your web-based entry. Please enter BSA, weight, and height at the time of earliest start date for the drug.

9. Drug # ☐☐

Specify:

- ☐ Total dose abstracted
- ☐ Total dose, some estimated
- ☐ Incomplete or Partial dose
- ☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose ☐☐☐☐☐

Indicate Dosage

- ☐ microgram
- ☐ gram
- ☐ milligram
- ☐ International Units

Body Surface Area ☐.☐☐

Weight (kg) ☐☐☐.☐

Height (cm) ☐☐☐.☐☐

10. Drug # ☐☐

Specify:

- ☐ Total dose abstracted
- ☐ Total dose, some estimated
- ☐ Incomplete or Partial dose
- ☐ No dose data

Date Started M M / D D / Y Y Y Y

Last Dose M M / D D / Y Y Y Y

Cumulative Total Dose ☐☐☐☐☐

Indicate Dosage

- ☐ microgram
- ☐ gram
- ☐ milligram
- ☐ International Units

Body Surface Area ☐.☐☐

Weight (kg) ☐☐☐.☐

Height (cm) ☐☐☐.☐☐

Please use a separate sheet of paper for additional treatments

D. SURGICAL PROCEDURES

1. Did this individual undergo any surgical procedures during this treatment period?
(This does not include placement of vascular access devices such as Broviac Catheters, Hickmans, Port-a-Caths, etc.) Include biopsies identified under general anesthesia. Do not include bone marrow aspirates, lumbar punctures, or needle biopsies. If more than one procedure was done during a surgery, enter each procedure separately.)

☐ No → ***Go to Radiation section E, page 10.***

☐ Yes

Please complete a copy of the Surgery Data Checklist and photocopy all operative notes.

a. Biopsy/Resection

1. Was there a biopsy or resection of the primary tumor?

☐ Yes

☐ No

b. Amputation

If diagnosis type is Bone Tumor or Soft Tissue Sarcoma:

1. Did the patient have an amputation of an extremity for any reason?

☐ No → ***Go to c. Limb Sparing Procedure.***

☐ Yes

2. Amputation Site

☐ Right Upper Extremity

☐ Left Upper Extremity

☐ Right Lower Extremity

☐ Left Lower Extremity

3. Amputation Date

M M / D D / Y Y Y Y

c. Limb Sparing Procedure

If diagnosis type is Bone Tumor or Soft Tissue Sarcoma:

1. Did the patient have a limb sparing procedure?

☐ No → ***Go to Radiation section E, page 10.***

☐ Yes

2. Limb Sparing Site

☐ Right Upper Extremity

☐ Left Upper Extremity

☐ Right Lower Extremity

☐ Left Lower Extremity

3. Limb Sparing Date

M M / D D / Y Y Y Y

d. Splenectomy

If diagnosis type is Hodgkin Lymphoma:

1. Did the patient have a splenectomy?

☐ No → ***Go to Radiation section E, page 10.***

☐ Yes

2. Splenectomy Date

M M / D D / Y Y Y Y

E. RADIATION

1. Did this individual receive radiation therapy during this treatment period?

☐ No → ***Abstraction for this Additional Treatment Period complete.***

☐ Yes

☐ Unclear → ***If Unclear, use Comments section on back of form to specify reason.***

Record start and stop dates for each radiation treatment (course). If the time gap between the stop date of one course of radiation therapy and the start date of another course of radiation is more than 3 months begin a new entry with the next start date. Each brachytherapy treatment is considered a separate treatment or entry.

Remember, if a period of 6 months or more without ANY treatment occurs, any subsequent therapy (Chemotherapy, Surgery, Radiation) will be entered into the Medical Records Abstraction Worksheet ADDENDUM.

Please complete a copy of the Radiotherapy and/or Brachytherapy Data Checklist and copy radiation information for all date entries.

1. a. Date Start Radiotherapy

M M / D D / Y Y Y Y

b. Date Stop Radiotherapy

M M / D D / Y Y Y Y

c. Body Site for Radiotherapy *(Check ALL that apply.)*

☐ Brain ☐ Pelvis
☐ Head other ☐ Limb
☐ Neck ☐ Total body irradiation
☐ Chest ☐ Unknown
☐ Spine ☐ Other
☐ Abdomen

If Other, please specify.

Radiotherapy facility name	**Radiotherapy facility address**	**Radiotherapy facility phone number**

2. a. Date Start Radiotherapy

M M / D D / Y Y Y Y

b. Date Stop Radiotherapy

M M / D D / Y Y Y Y

c. Body Site for Radiotherapy *(Check ALL that apply.)*

☐ Brain ☐ Pelvis
☐ Head other ☐ Limb
☐ Neck ☐ Total body irradiation
☐ Chest ☐ Unknown
☐ Spine ☐ Other
☐ Abdomen

If Other, please specify.

Radiotherapy facility name *(If different from above)*	**Radiotherapy facility address** *(If different from above)*	**Radiotherapy facility phone number** *(If different from above)*

3. a. Date Start Radiotherapy

M M / D D / Y Y Y Y

b. Date Stop Radiotherapy

M M / D D / Y Y Y Y

c. Body Site for Radiotherapy *(Check ALL that apply.)*

- ☐ Brain
- ☐ Head other
- ☐ Neck
- ☐ Chest
- ☐ Spine
- ☐ Abdomen
- ☐ Pelvis
- ☐ Limb
- ☐ Total body irradiation
- ☐ Unknown
- ☐ Other

If Other, please specify.

Radiotherapy facility name *(If different from above)*	**Radiotherapy facility address** *(If different from above)*	**Radiotherapy facility phone number** *(If different from above)*

4. a. Date Start Radiotherapy

M M / D D / Y Y Y Y

b. Date Stop Radiotherapy

M M / D D / Y Y Y Y

c. Body Site for Radiotherapy *(Check ALL that apply.)*

- ☐ Brain
- ☐ Head other
- ☐ Neck
- ☐ Chest
- ☐ Spine
- ☐ Abdomen
- ☐ Pelvis
- ☐ Limb
- ☐ Total body irradiation
- ☐ Unknown
- ☐ Other

If Other, please specify.

Radiotherapy facility name *(If different from above)*	**Radiotherapy facility address** *(If different from above)*	**Radiotherapy facility phone number** *(If different from above)*

5. a. Date Start Radiotherapy

M M / D D / Y Y Y Y

b. Date Stop Radiotherapy

M M / D D / Y Y Y Y

c. Body Site for Radiotherapy *(Check ALL that apply.)*

- ☐ Brain
- ☐ Head other
- ☐ Neck
- ☐ Chest
- ☐ Spine
- ☐ Abdomen
- ☐ Pelvis
- ☐ Limb
- ☐ Total body irradiation
- ☐ Unknown
- ☐ Other

If Other, please specify.

Radiotherapy facility name *(If different from above)*	**Radiotherapy facility address** *(If different from above)*	**Radiotherapy facility phone number** *(If different from above)*

Please use a separate sheet of paper for additional treatments

Comments: