

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
<input type="text"/>	<input type="text"/>

 /

D	D
<input type="text"/>	<input type="text"/>

 /

Y	Y	Y	Y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Primary Diagnosis: _____

Person Completing this Worksheet: _____
(Please print)

Institutional Password:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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CCSS 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"/>
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Today's Date:

<input type="text"/>	<input type="text"/>
M	M

 /

<input type="text"/>	<input type="text"/>
D	D

 /

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Y	Y	Y	Y

This Medical Record Abstraction Worksheet ADDENDUM is

<input type="text"/>	<input type="text"/>
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 of

<input type="text"/>	<input type="text"/>
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 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.

<p>Protocol 1</p> <p>Study Group (Select only one)</p> <p><input type="checkbox"/> CCG <input type="checkbox"/> St. Jude</p> <p><input type="checkbox"/> POG <input type="checkbox"/> None</p> <p><input type="checkbox"/> SWOG <input type="checkbox"/> Other</p> <p><input type="checkbox"/> CALGB <input style="border: 1px solid black; padding: 2px; width: 100px;" type="text" value="Specify group"/></p> <p>Protocol #</p> <table style="border-collapse: collapse; width: 100%;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>											<p>Protocol 2</p> <p>Study Group (Select only one)</p> <p><input type="checkbox"/> CCG <input type="checkbox"/> St. Jude</p> <p><input type="checkbox"/> POG <input type="checkbox"/> None</p> <p><input type="checkbox"/> SWOG <input type="checkbox"/> Other</p> <p><input type="checkbox"/> CALGB <input style="border: 1px solid black; padding: 2px; width: 100px;" type="text" value="Specify group"/></p> <p>Protocol #</p> <table style="border-collapse: collapse; width: 100%;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>											<p>Protocol 3</p> <p>Study Group (Select only one)</p> <p><input type="checkbox"/> CCG <input type="checkbox"/> St. Jude</p> <p><input type="checkbox"/> POG <input type="checkbox"/> None</p> <p><input type="checkbox"/> SWOG <input type="checkbox"/> Other</p> <p><input type="checkbox"/> CALGB <input style="border: 1px solid black; padding: 2px; width: 100px;" type="text" value="Specify group"/></p> <p>Protocol #</p> <table style="border-collapse: collapse; width: 100%;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td><td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> </table>										

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

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 (Cytosan) IV/IM	22 Methotrexate IM	34 Zinecard (Dexrazoxane) IV/IM
11 Cyclophosphamide (Cytosan) 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.

<p>1. Drug #</p> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px;"></div> <p>Specify:</p> <p><input type="checkbox"/> Total dose abstracted</p> <p><input type="checkbox"/> Total dose, some estimated</p> <p><input type="checkbox"/> Incomplete or Partial dose</p> <p><input type="checkbox"/> No dose data</p>	<p>Date Started</p> <p>M M D D Y Y Y Y</p> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>
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8 Chlorambucil PO	20 Melphalan PO	32 VP-16 (Etoposide) IV/IM
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12 Daunorubicin (Daunomycin) IV/IM	24 Mitoxantrone (Novantrone) IV/IM	

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<p>3. Drug #</p> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> <p>Specify:</p> <p><input type="checkbox"/> Total dose abstracted</p> <p><input type="checkbox"/> Total dose, some estimated</p> <p><input type="checkbox"/> Incomplete or Partial dose</p> <p><input type="checkbox"/> No dose data</p>	<p>Date Started</p> <p>M M D D Y Y Y Y</p> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	<p>Body Surface Area <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></p> <p>Weight (kg) <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></p> <p>Height (cm) <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></p>
	<p>Last Dose</p> <p>M M D D Y Y Y Y</p> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	
	<p>Cumulative Total Dose</p> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	<p>Indicate Dosage</p> <p><input type="checkbox"/> microgram <input type="checkbox"/> gram</p> <p><input type="checkbox"/> milligram <input type="checkbox"/> International Units</p>
<p>4. Drug #</p> <div style="border: 1px solid black; width: 40px; height: 20px; margin: 5px 0;"></div> <p>Specify:</p> <p><input type="checkbox"/> Total dose abstracted</p> <p><input type="checkbox"/> Total dose, some estimated</p> <p><input type="checkbox"/> Incomplete or Partial dose</p> <p><input type="checkbox"/> No dose data</p>	<p>Date Started</p> <p>M M D D Y Y Y Y</p> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> / <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div>	<p>Body Surface Area <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></p> <p>Weight (kg) <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></p> <p>Height (cm) <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> . <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></div></p>
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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 # <input type="text"/> <input type="text"/>	Date Started M M D D Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Body Surface Area <input type="text"/> . <input type="text"/> <input type="text"/>
Specify: <input type="checkbox"/> Total dose abstracted <input type="checkbox"/> Total dose, some estimated <input type="checkbox"/> Incomplete or Partial dose <input type="checkbox"/> No dose data	Last Dose M M D D Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Weight (kg) <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>
	Cumulative Total Dose <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Dosage <input type="checkbox"/> microgram <input type="checkbox"/> gram <input type="checkbox"/> milligram <input type="checkbox"/> International Units

10. Drug # <input type="text"/> <input type="text"/>	Date Started M M D D Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Body Surface Area <input type="text"/> . <input type="text"/> <input type="text"/>
Specify: <input type="checkbox"/> Total dose abstracted <input type="checkbox"/> Total dose, some estimated <input type="checkbox"/> Incomplete or Partial dose <input type="checkbox"/> No dose data	Last Dose M M D D Y Y Y Y <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Weight (kg) <input type="text"/> <input type="text"/> <input type="text"/> . <input type="text"/>
	Cumulative Total Dose <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Indicate Dosage <input type="checkbox"/> microgram <input type="checkbox"/> gram <input type="checkbox"/> milligram <input type="checkbox"/> International Units

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.

<p>1. a. Date Start Radiotherapy</p> <p style="text-align: center;">M M D D Y Y Y Y</p> <p style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </p> <p>b. Date Stop Radiotherapy</p> <p style="text-align: center;">M M D D Y Y Y Y</p> <p style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </p>	<p>c. Body Site for Radiotherapy (Check ALL that apply.)</p> <p> <input type="checkbox"/> Brain <input type="checkbox"/> Pelvis <input type="checkbox"/> Head other <input type="checkbox"/> Limb <input type="checkbox"/> Neck <input type="checkbox"/> Total body irradiation <input type="checkbox"/> Chest <input type="checkbox"/> Unknown <input type="checkbox"/> Spine <input type="checkbox"/> Other <input type="checkbox"/> Abdomen </p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p><i>If Other, please specify.</i></p> </div>	
<p>Radiotherapy facility name</p>	<p>Radiotherapy facility address</p>	<p>Radiotherapy facility phone number</p>
<p>2. a. Date Start Radiotherapy</p> <p style="text-align: center;">M M D D Y Y Y Y</p> <p style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </p> <p>b. Date Stop Radiotherapy</p> <p style="text-align: center;">M M D D Y Y Y Y</p> <p style="text-align: center;"> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> </p>	<p>c. Body Site for Radiotherapy (Check ALL that apply.)</p> <p> <input type="checkbox"/> Brain <input type="checkbox"/> Pelvis <input type="checkbox"/> Head other <input type="checkbox"/> Limb <input type="checkbox"/> Neck <input type="checkbox"/> Total body irradiation <input type="checkbox"/> Chest <input type="checkbox"/> Unknown <input type="checkbox"/> Spine <input type="checkbox"/> Other <input type="checkbox"/> Abdomen </p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p><i>If Other, please specify.</i></p> </div>	
<p>Radiotherapy facility name <i>(If different from above)</i></p>	<p>Radiotherapy facility address <i>(If different from above)</i></p>	<p>Radiotherapy facility phone number <i>(If different from above)</i></p>

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.)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Head other | <input type="checkbox"/> Limb |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Total body irradiation |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Spine | <input type="checkbox"/> Other |
| <input type="checkbox"/> 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)

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.)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Head other | <input type="checkbox"/> Limb |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Total body irradiation |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Spine | <input type="checkbox"/> Other |
| <input type="checkbox"/> 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)

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.)

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Pelvis |
| <input type="checkbox"/> Head other | <input type="checkbox"/> Limb |
| <input type="checkbox"/> Neck | <input type="checkbox"/> Total body irradiation |
| <input type="checkbox"/> Chest | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Spine | <input type="checkbox"/> Other |
| <input type="checkbox"/> 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)

Please use a separate sheet of paper for additional treatments

Comments: