

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Completed By: _____ Completion Date (MM/DD/YYYY): _____

Form Notes: An Enrollment Form should be completed for each TCGA qualified case upon qualification notice from the BCR. All information provided on this form should include activity from the Date of Initial Pathologic Diagnosis to the most recent Date of Last Contact with the patient. Questions regarding this form should be directed to the Tissue Source Site's (TSS) primary Clinical Outreach Contact at the BCR

The following definitions for the use of "Unknown" and "Not Evaluated" on this form are as follows:

Unknown: This answer option should only be selected if the TSS cannot answer the question because the answer is not known at the TSS. If this answer option is selected for a question that is part of the TCGA required data set, the TSS must complete a discrepancy note providing the reason why the answer is unknown.

Not Evaluated: This answer option should be selected by the TSS if it is known that the information being requested cannot be obtained due to the test not being performed.

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
1	Has this TSS received permission from NCI to provide time intervals as a substitute for requested dates on this form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please note that time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box to the left. Note 1: Provided time intervals must begin with the date of initial pathologic diagnosis. (i.e., biopsy or resection) Note 2: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
2	Primary Site of Disease*	<input type="checkbox"/> Kidney	2735776 Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for TCGA.
3	Histological Subtype*	<input type="checkbox"/> Kidney Clear Cell Renal Carcinoma (if checking this box, please complete question #4) <input type="checkbox"/> Kidney Papillary Renal Cell Carcinoma (if checking this box, please complete question #5) <input type="checkbox"/> Kidney Chromophobe Renal Cell Carcinoma (if checking this box, please complete questions #6 & #7)	3081934 Using the patient's pathology/laboratory report, select the histology and/or subtype of the tumor submitted for TCGA. Note: All other subtypes not listed are excluded from this study.
4	Tumor Grade <i>(Clear Cell Renal Carcinomas Only)</i>	<input type="checkbox"/> G1 Well differentiated <input type="checkbox"/> G2 Moderately differentiated <input type="checkbox"/> G3 Poorly differentiated <input type="checkbox"/> G4 Undifferentiated <input type="checkbox"/> GX Grade cannot be assessed	2785839 Using the patient's pathology/laboratory report, select the tumor grade of the tumor submitted for TCGA.
5	Tumor Type <i>(Papillary Renal Cell Carcinomas Only)</i>	<input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type Unknown	3104937 Using the patient's pathology/laboratory report, select the morphologic subtype of papillary renal cell carcinoma for the tumor submitted for TCGA.
6	Presence of Sarcomatoid Features <i>(Chromophobe Renal Cell Carcinomas Only)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not Evaluated	2429787 Using the patient's pathology/laboratory report, indicate if sarcomatoid features were present in the kidney tumor.
7	Percent of Tumor that is Sarcomatoid <i>(Chromophobe Renal Cell Carcinomas Only)</i>	_____	2429786 If sarcomatoid features are present in the kidney tumor, indicate the percentage of sarcomatoid features.
8	Tumor Laterality	<input type="checkbox"/> Right (Kidney) <input type="checkbox"/> Left (Kidney) <input type="checkbox"/> Bilateral	827 Using the patient's pathology/laboratory report and medical record, designate the side of the body where the cancer is located.

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
9	Is This a Prospective Tissue Collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3088492 Indicate whether the TSS providing tissue is contracted for prospective tissue collection. If the submitted tissue was collected for the specific purpose of TCGA, the tissue has been collected prospectively.
10	Is This a Retrospective Tissue Collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3088528 Indicate whether the TSS providing tissue is contracted for retrospective tissue collection. If the submitted tissue was collected prior to the date the TCGA contract was executed, the tissue has been collected retrospectively.
11	Gender*	<input type="checkbox"/> Female <input type="checkbox"/> Male	2200604 Provide the patient's gender using the defined categories. Identification of gender is based upon self-report and may come from a form, questionnaire, interview, etc.
12	Month of Birth	<input type="checkbox"/> <input type="checkbox"/> (MM)	2896950 Provide the month the patient was born
13	Day of Birth	<input type="checkbox"/> <input type="checkbox"/> (DD)	2896952 Provide the day the patient was born.
14	Year of Birth	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2896954 Provide the year the patient was born.
15	Number of Days from Date of Initial Pathologic Diagnosis to Date of Birth	_____	3008233 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of Birth. Note: Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
16	Race	<input type="checkbox"/> American Indian or Alaska Native (A person having origins in any of the original peoples of North/ South America (including Central America), and maintains tribal affiliation or community attachment) <input type="checkbox"/> Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam) <input type="checkbox"/> White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa) <input type="checkbox"/> Black or African American (A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American") <input type="checkbox"/> Native Hawaiian or other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands) <input type="checkbox"/> Not Evaluated (Not provided or available) <input type="checkbox"/> Unknown (Could not be determined or unsure)	2192199 Provide the patient's race using the defined categories.
17	Ethnicity	<input type="checkbox"/> Not Hispanic or Latino (A person not meeting the definition for Hispanic or Latino) <input type="checkbox"/> Hispanic or Latino (A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race) <input type="checkbox"/> Not Evaluated (Not provided or available) <input type="checkbox"/> Unknown (Could not be determined or unsure)	2192217 Provide the patient's ethnicity using the defined categories

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
18	Has the Patient Had Any Prior Cancer Diagnosed?*	<input type="checkbox"/> No <input type="checkbox"/> History of Prior Malignancy <input type="checkbox"/> History of Synchronous / Bilateral Malignancy	3382736 Indicate whether the patient has a history of prior malignancies. Note 1: If this question cannot be answered because the answer is unknown, the case will be excluded from TCGA. Note 2: If the patient has any history of prior malignancies, including synchronous or bilateral malignancies, please complete an "Other Malignancy Form" for each malignancy diagnosed prior to the procurement of the tissue submitted for TCGA. If the patient has a history of multiple diagnoses of basal and/or squamous cell skin cancers, complete an "Other Malignancy Form" for the first diagnosis for each of these types.
19	History of Neo-adjuvant Treatment for Tumor Specimen Submitted for TCGA*	<input type="checkbox"/> No <input type="checkbox"/> Radiation Prior to Sample Procurement <input type="checkbox"/> Pharmaceutical Treatment Prior to Sample Procurement <input type="checkbox"/> Both Pharmaceutical and Radiation Treatment Prior to Sample Procurement	3382737 Indicate whether the patient received therapy for this cancer prior to sample procurement of the tumor submitted for TCGA. If the patient did receive treatment for this cancer prior to procurement, the TSS should contact the BCR for further instructions. Note: Systemic treatment and certain localized therapies (those administered to the same site as the TCGA submitted tissue) given prior to procurement of the sample submitted for TCGA are exclusionary.
Date of Initial Pathologic Diagnosis			
20	Month of Initial Pathologic Diagnosis*	<input type="checkbox"/> <input type="checkbox"/> (MM)	2896956 Provide the month the patient was initially diagnosed with the malignancy submitted for TCGA
21	Day of Initial Pathologic Diagnosis	<input type="checkbox"/> <input type="checkbox"/> (DD)	2896958 Provide the day the patient was initially diagnosed with the malignancy submitted for TCGA
22	Year of Initial Pathologic Diagnosis*	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2896960 Provide the year the patient was initially diagnosed with the malignancy submitted for TCGA
23	Were Lymph Nodes Examined at the Time of Primary Presentation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2200396 Indicate whether any lymph nodes were examined at the time of the primary resection.
24	Number of Lymph Nodes Examined	<input type="checkbox"/> <input type="checkbox"/>	3 Provide the number of lymph nodes pathologically assessed if one or more lymph nodes were removed.
25	Number of Lymph Nodes Positive	<input type="checkbox"/> <input type="checkbox"/>	89 Provide the number of lymph nodes involved with disease as determined by pathologic examination.
26	AJCC Cancer Staging Handbook Edition *	<input type="checkbox"/> First Edition (1978-1983) <input type="checkbox"/> Second Edition (1984-1988) <input type="checkbox"/> Third Edition (1989-1992) <input type="checkbox"/> Fourth Edition (1993-1997) <input type="checkbox"/> Fifth Edition (1998-2002) <input type="checkbox"/> Sixth Edition (2003-2009) <input type="checkbox"/> Seventh Edition (2010-Current)	2722309 Indicate the AJCC Cancer Staging Edition that was used to answer the following staging questions.

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
27	Pathologic Spread: Primary Tumor (pT)*	<input type="checkbox"/> TX <input type="checkbox"/> T1a <input type="checkbox"/> T2a <input type="checkbox"/> T3a <input type="checkbox"/> T4 <input type="checkbox"/> T0 <input type="checkbox"/> T1b <input type="checkbox"/> T2b <input type="checkbox"/> T3b <input type="checkbox"/> T4a <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T3c <input type="checkbox"/> T4b	3045435 Using the patient's pathology/laboratory report, select the code for the pathologic T (primary tumor) defined by the American Joint Committee on Cancer (AJCC).
28	Pathologic Spread: Lymph Nodes (pN)*	<input type="checkbox"/> NX <input type="checkbox"/> N1 <input type="checkbox"/> N3 <input type="checkbox"/> N0 <input type="checkbox"/> N2 <input type="checkbox"/> N4	3065858 Using the patient's pathology/laboratory report, select the code for the pathologic N (nodal) defined by the American Joint Committee on Cancer (AJCC).
29	Clinical Spread: Distant Metastases (M)	<input type="checkbox"/> MX <input type="checkbox"/> M0 <input type="checkbox"/> M1	3440331 Using the patient's medical record, select the code for the clinical M (metastasis) as defined by the American Joint Committee on Cancer (AJCC). Note: Do not answer this question if there is pathologic evidence of metastasis.
30	Pathological Spread: Distant Metastases (M)	<input type="checkbox"/> MX <input type="checkbox"/> M0 <input type="checkbox"/> M1	3045439 Using the patient's pathology/laboratory report in conjunction with the patient's medical record, select the code for the clinical or pathological M (metastasis) as defined by the American Joint Committee on Cancer (AJCC). Note: Only answer this question if there is pathologic confirmation of metastatic disease.
31	Tumor Stage (Pathological and/or Clinical)*	<input type="checkbox"/> Stage I <input type="checkbox"/> Stage III <input type="checkbox"/> Stage II <input type="checkbox"/> Stage IV	3065862 Using the patient's pathology/laboratory report, in conjunction with the patient's medical record, select the stage defined by the American Joint Committee on Cancer (AJCC).
32	Vital Status*	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	2939553 Indicate whether the patient was living or deceased at the date of last contact.
Date of Last Contact			
33	Month of Last Contact	<input type="checkbox"/> <input type="checkbox"/> (MM)	2897020 Provide the month of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). Note: Do not answer this question if the patient is deceased.
34	Day of Last Contact	<input type="checkbox"/> <input type="checkbox"/> (DD)	2897022 Provide the day of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). Note: Do not answer this question if the patient is deceased.
35	Year of Last Contact	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2897024 Provide the year of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). Note: Do not answer this question if the patient is deceased.
36	Number of Days from Date of Initial Pathologic Diagnosis to Date of Last Contact	_____	3008273 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of last contact. Note 1: Do not answer this question if the patient is deceased. Note 2: Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
Date of Death <input type="checkbox"/> Not Applicable (Patient is Alive)			
37	Month of Death	<input type="checkbox"/> <input type="checkbox"/> (MM)	2897026 If the patient is deceased, provide the month of death.
38	Day of Death	<input type="checkbox"/> <input type="checkbox"/> (DD)	2897028 If the patient is deceased, provide the day of death.
39	Year of Death	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2897030 If the patient is deceased, provide the year of death.
40	Number of Days from Date of Initial Pathologic Diagnosis to Date of Death	_____	3165475 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of last contact. Note: Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
41	Tumor Status	<input type="checkbox"/> Tumor Free <input type="checkbox"/> With Tumor <input type="checkbox"/> Unknown Tumor Status	2759550 Indicate whether the patient was tumor/disease free at the date of last contact or death.
Prognostic/Predictive/Lifestyle Features Used for Tumor Prognosis or Responsiveness to Treatment			
42	LDH	<input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	3113468 Indicate the outcome of LDH test results.
43	Serum Calcium	<input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	3113470 Indicate the outcome of serum calcium test results.
44	Hemoglobin	<input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	3113466 Indicate the outcome of hemoglobin test results.
45	Platelets	<input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	3104944 Indicate the outcome of platelet test results.
46	White Cell Count	<input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	3104948 Indicate the outcome of white cell count test results.
47	Erythrocyte Sedimentation Rate	<input type="checkbox"/> Elevated <input type="checkbox"/> Normal <input type="checkbox"/> Low <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	3104952 Indicate the outcome of erythrocyte sedimentation rate (ESR) test results.
48	Tobacco Smoking History Indicator*	<input type="checkbox"/> Lifelong Non-smoker (<100 cigarettes smoked in Lifetime) <input type="checkbox"/> Current smoker (includes daily smokers and non-daily smokers (or occasional smokers) <input type="checkbox"/> Current reformed smoker for > 15 years (greater than 15 yrs) <input type="checkbox"/> Current reformed smoker for ≤15 years (less than or equal to 15 yrs) <input type="checkbox"/> Current reformed smoker, duration not specified <input type="checkbox"/> Smoking History not Documented	2181650 Indicate the patient's current smoking status or smoking history as self reported by the patient.
49	Year of Onset of Tobacco Smoking	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2228604 If the patient is a current or reformed smoker, indicate the year in which the patient began smoking.
50	Year of Quitting Tobacco Smoking	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2228610 If the patient is a reformed smoker, indicate the year in which the patient quit smoking.

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
Prognostic/Predictive/Lifestyle Factors (Used for Tumor Prognosis or Responsiveness to Treatment)			
51	Number Pack Years Smoked	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Number Pack Years	2955385 Indicate the lifetime tobacco exposure of the patient. Number of pack years is defined as the number of cigarettes smoked per day times (x) the number of years smoked divided (/) by 20.
52	Performance Status Score: Karnofsky Score (Pre-Operative)	<input type="checkbox"/> 100 Normal, no complaints; no evidence of disease <input type="checkbox"/> 90 Able to carry on normal activity; minor signs or symptoms of disease <input type="checkbox"/> 80 Normal activity with effort; some signs or symptoms of disease <input type="checkbox"/> 70 Cares for self; unable to carry on normal activity or to do active work <input type="checkbox"/> 60 Requires occasional assistance; but is able to care for most of his/her needs <input type="checkbox"/> 50 Requires considerable assistance and frequent medical care <input type="checkbox"/> 40 Disabled; requires special care <input type="checkbox"/> 30 Severely disabled <input type="checkbox"/> 20 Very sick; requiring hospitalization <input type="checkbox"/> 10 Moribund; fatal processes progressing rapidly <input type="checkbox"/> 0 Dead <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	2003853 Provide the patient's Karnofsky Score using the defined categories. This score represents the functional capabilities of the patient.
53	Performance Status Score: Eastern Cooperative Oncology Group	<input type="checkbox"/> 0 Asymptomatic <input type="checkbox"/> 1 Symptomatic, but fully ambulatory <input type="checkbox"/> 2 Symptomatic, in bed less than 50% of day <input type="checkbox"/> 3 Symptomatic, in bed more than 50% of day, but not bed ridden <input type="checkbox"/> 4 Bed-ridden <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	88 Provide the patient's Eastern Cooperative Oncology Group (ECOG) score using the defined categories. This score represents the functional performance status of the patient.
54	Performance Status Score: Timing	<input type="checkbox"/> Post Adjuvant Therapy <input type="checkbox"/> Post Secondary Therapy <input type="checkbox"/> At Recurrence/Progression of Disease <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Other <input type="checkbox"/> Unknown	2792763 Provide a time reference for the Karnofsky score and/or the ECOG score using the defined categories.
Primary Treatment			
55	Adjuvant Post-Operative Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2005312 Indicate whether the patient had adjuvant/ post-operative radiation therapy. Note: If the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
56	Adjuvant Post-Operative Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2785850 Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy. Note: If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.
57	Measure of Success of Outcome at the Completion of Initial First Course Treatment (surgery and adjuvant therapies)	<input type="checkbox"/> Partial Response <input type="checkbox"/> Stable Disease <input type="checkbox"/> Unknown <input type="checkbox"/> Complete Response <input type="checkbox"/> Progressive Disease <input type="checkbox"/> Not Evaluated	2786727 Provide the patient's response to their initial first course treatment.
New Tumor Event: Complete the section below if the patient had a new tumor event after tissue procurement and prior to submission of this Enrollment Form. If the patient did not have a new tumor event, or if the TSS does not know, indicate this in the first questions and skip the remainder of this form.			
58	New Tumor Event After Initial Treatment*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3121376 Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after their initial treatment for the tumor submitted to TCGA. If the patient had multiple new tumor events, a follow-up form should be completed for each new tumor event.
Date of New Tumor Event After Initial Treatment			
59	Month of New Tumor Event After Initial Treatment	<input type="checkbox"/> <input type="checkbox"/> (MM)	3104044 If the patient had a new tumor event, provide the month of diagnosis for this new tumor event.
60	Day of New Tumor Event After Initial Treatment	<input type="checkbox"/> <input type="checkbox"/> (DD)	3104042 If the patient had a new tumor event, provide the day of diagnosis for this new tumor event.
61	Year of New Tumor Event After Initial Treatment	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	3104046 If the patient had a new tumor event, provide the year of diagnosis for this new tumor event.
62	Number of Days from Date of Initial Pathologic Diagnosis to Date of New Tumor Event	_____	3392464 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of new tumor event. Note: Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
63	Additional Surgery for New Tumor Event Loco-regional Procedure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3008755 Using the patient's medical records, indicate whether the patient had surgery for the new loco-regional tumor event in question.
Date of Additional Surgery for New Tumor Event Loco-Regional			
64	Month of Additional Surgery for New Tumor Event Locoregional	<input type="checkbox"/> <input type="checkbox"/> (MM)	2897032 If the patient had surgery for the new loco-regional tumor event, provide the month of surgery for this new loco-regional tumor event.
65	Day of Additional Surgery for New Tumor Event Locoregional	<input type="checkbox"/> <input type="checkbox"/> (DD)	2897034 If the patient had surgery for the new loco-regional tumor event, provide the day of surgery for this new loco-regional tumor event.
66	Year of Additional Surgery for New Tumor Event Locoregional	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2897036 If the patient had surgery for the new loco-regional tumor event, provide the year of surgery for this new loco-regional tumor event.

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
67	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event Locoregional	_____	3408572 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of additional surgery for new tumor event (Local-Regional). Note: Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
68	Additional Surgery for New Tumor Event Metastatic	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3008757 Using the patient's medical records, indicate whether the patient had surgery for the new metastatic tumor event in question.
Date of Additional Surgery for New Tumor Event Metastasis			
69	Month of Additional Surgery for New Tumor Event Metastatic	<input type="checkbox"/> <input type="checkbox"/> (MM)	2897038 If the patient had surgery for the new metastatic tumor event, provide the month of surgery for this new metastatic tumor event.
70	Day of Additional Surgery for New Tumor Event Metastatic	<input type="checkbox"/> <input type="checkbox"/> (DD)	2897040 If the patient had surgery for the new metastatic tumor event, provide the day of surgery for this new metastatic tumor event.
71	Year of Additional Surgery for New Tumor Event Metastatic	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)	2897042 If the patient had surgery for the new metastatic tumor event, provide the year of surgery for this new metastatic tumor event.
72	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event Metastatic	_____	3408682 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of additional surgery for new tumor event (metastasis). Note: Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.
Additional Treatment			
73	Additional treatment of New Tumor Event Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3008761 Indicate whether the patient received radiation treatment for this new tumor event.
74	Additional Treatment of New Tumor Event Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2650646 Indicate whether the patient received pharmaceutical treatment for this new tumor event.

Comments:

Principal Investigator Name: _____ Principal Investigator Signature: _____

Date Signed (MM/DD/YYYY): _____