Enrollment: Lung

V4.0

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 the NCI to provide time intervals as a substitute for requested dates on this form?	☐ Yes ☐ 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	☐ Lung	2735776 Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for TCGA.
3	Diagnosis	☐ Squamous Cell Carcinoma *(if checked, please complete Question #3)* ☐ Adenocarcinoma *(if checked, please complete Question #4)*	3081932 Using the patient's pathology/laboratory report, select the histologic diagnosis of the tumor submitted for TCGA.
4	Histological Subtype (Squamous Cell)	☐ Papillary Squamous Cell Carcinoma ☐ Clear Cell Squamous Cell Carcinoma ☐ Small Cell Squamous Cell Carcinoma ☐ Basaloid Squamous Cell Carcinoma ☐ Squamous Cell Carcinoma, Not Otherwise Specified (NOS)	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.***
5	Histological Subtype (Adenocarcinoma)	☐ Adenocarcinoma, Mixed Subtype ☐ Acinar Adenocarcinoma ☐ Papillary Adenocarcinoma ☐ Bronchioloalveolar Carcinoma, Mucinous ☐ Bronchioloalveolar Carcinoma, Non-Mucinous ☐ Solid Pattern Predominant Adenocarcinoma ☐ Micropapillary Adenocarcinoma ☐ Fetal Adenocarcinoma ☐ Mucinous Cystadenocarcinoma ☐ Mucinous (Colloid) Adenocarcinoma ☐ Signet Ring Adenocarcinoma ☐ Clear Cell Adenocarcinoma ☐ Adenocarcinoma, Not Otherwise Specified (NOS)	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.***
6	Anatomic Organ Sub-division	☐ Right Upper Lobe ☐ Right Middle Lobe ☐ Right Lower Lobe ☐ Bronchus ☐ Left Upper Lobe ☐ Left Lower Lobe ☐ Other *(please specify)*	2008006 Using the patient's pathology/laboratory report, select the anatomic organ sub-division of the tumor used for TCGA.

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Question#	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
7	Other Anatomic Organ Sub-Division	_____	3407703 If the anatomic organ sub-division is not included in the provided list, specify the other anatomic organ sub-division of the tumor used for TCGA
8	Location in Lung Parenchyma	☐ Peripheral Lung ☐ Central Lung ☐ Unknown	3139453 Using the patient's pathology/laboratory report, in conjunction with the patient's medical record select the location of the tumor within the lung parenchyma.
9	Is This a Prospective Tissue Collection?	☐ Yes ☐ 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?	☐ Yes ☐ 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	☐ Male ☐ Female	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.
Date of Birth			
12	Month of Birth	☐☐ (MM)	2896950 Provide the month the patient was born.
13	Day of Birth	☐☐ (DD)	2896952 Provide the day the patient was born.
14	Year of Birth	☐☐☐☐ (YYYY)	2896954 Provide the year the patient was born.
15	Number of Days from Date of Initial Pathological 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	☐ American Indian or Alaska Native (A person having origins in any original peoples of North and South America, and maintains tribal affiliation/ community attachment. ☐ Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or Indian subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam) ☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa) ☐ Black or African American (A person having origins in any black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American. ☐ Native Hawaiian or other Pacific Islander (A person having origins in any original peoples of Hawaii, Guam, Samoa, or other Pacific Islands) ☐ Not Evaluated (Not provided or available) ☐ Unknown (Could not be determined or unsure)	2192199 Provide the patient's race using the defined categories.

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Question#	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
17	Ethnicity	☐ Not Hispanic or Latino (A person not meeting the definition for Hispanic or Latino) ☐ Hispanic or Latino (A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race) ☐ Not Evaluated (Not provided or available) ☐ Unknown (Could not be determined or unsure)	2192217 Provide the patient's ethnicity using the defined categories
18	Has the Patient Had Any Prior Cancer Diagnosed?	☐ No ☐ History of Prior Malignancy ☐ 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 to Tumor Specimen Submitted for TCGA	☐ No ☐ Radiation Prior to Sample Procurement ☐ Pharmaceutical Treatment Prior to Sample Procurement ☐ 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 (of Lung Tumor Associated with Tissue Procurement for TCGA)			
20	Month of Initial Pathologic Diagnosis	☐☐ (MM)	2896956 Provide the month the patient was initially pathologically diagnosed with the malignancy submitted for TCGA.
21	Day of Initial Pathologic Diagnosis	☐☐ (DD)	2896958 Provide the day the patient was initially pathologically diagnosed with the malignancy submitted for TCGA.
22	Year of Initial Pathologic Diagnosis	☐☐☐☐ (YYYY)	2896960 Provide the year the patient was initially pathologically diagnosed with the malignancy submitted for TCGA.
23	Residual Tumor	☐ Not Evaluated ☐ RX ☐ R0 ☐ R1 ☐ R2	2608702 Using the patient's pathology/laboratory report, select the tissue margin status at time of surgical resection for the tumor submitted for TCGA.
24	AJCC Cancer Staging Handbook Edition	☐ First Edition (1978-1983) ☐ Second Edition (1984-1988) ☐ Third Edition (1989-1992) ☐ Fourth Edition (1993-1997) ☐ Fifth Edition (1998-2002) ☐ Sixth Edition (2003-2009) ☐ Seventh Edition (2010-Current)	2722309 Indicate the AJCC Cancer Staging Edition that was used to answer the following staging questions.
25	Pathologic Spread: Primary Tumor (pT)	☐ TX ☐ T0 ☐ T1 ☐ T1a ☐ T1b ☐ T2 ☐ T2a ☐ T2b ☐ T3 ☐ T4	3045435 Using the patient's pathology/laboratory report, select the code for the pathologic T (primary tumor) as defined by the American Joint Committee on Cancer (AJCC).

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Question#	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
26	Pathologic Spread: Lymph Nodes (pN)	☐ NX ☐ N1 ☐ N3 ☐ N0 ☐ N2	3065858 Using the patient's pathology/laboratory report, select the code for the pathologic N (nodal) as defined by the American Joint Committee on Cancer (AJCC).
27	Pathologic Spread: Distant Metastases (M) (clinical and/or pathological)	☐ MX ☐ M1a ☐ M0 ☐ M1b ☐ 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).
28	Tumor Stage (Pathological and/or Clinical)	☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IA ☐ Stage IIA ☐ Stage IIIA ☐ Stage IB ☐ Stage IIB ☐ Stage IIIB ☐ Stage IV	3065862 Using the patient's pathology/laboratory report, in conjunction with the patient's medical record select the stage as defined by the American Joint Committee on Cancer (AJCC).
29	Vital Status	☐ Living ☐ Deceased	2939553 Indicate whether the patient was living or deceased at the date of last contact.
Date of Last Contact			
30	Month of Last Contact	☐☐ (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.***
31	Day of Last Contact	☐☐ (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.***
32	Year of Last Contact	☐☐☐☐ (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.***
33	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: 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.***
Date of Death			
34	Month of Death	☐☐ (MM)	2897026 If the patient is deceased, provide the month of death.
35	Day of Death	☐☐ (DD)	2897028 If the patient is deceased, provide the day of death.
36	Year of Death	☐☐☐☐ (YYYY)	2897030 If the patient is deceased, provide the year of death.
37	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 death. ***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.***
38	Tumor Status	☐ Tumor Free ☐ Unknown Tumor Status ☐ With Tumor	2759550 Indicate whether the patient was tumor/disease free at the date of last contact or death.

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Question#	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
39	Pulmonary Function Tests Performed?	☐ Yes ☐ No	2556486 Indicate whether the patient had formal Pulmonary Function Tests (PFTs) performed. ***Note: If surgery is performed, pre-operative PFTs are preferred.***
40	FEV1% REF, pre-bronchodilator: (Pre- Bronchodilator Lung Forced Expiratory Volume I Test Lab Percentage Value)	☐☐☐ %	3302947 Identify the results for the pre-operative PFTs and indicate the percentage comparison to a normal value reference range of the volume of air that a patient can forcibly exhale from the lungs in one second **pre-bronchodilator.**
41	FEV1% REF, post-bronchodilator: (Post- Bronchodilator Lung Forced Expiratory Volume I Test Lab Percentage Value)	☐☐☐%	3302948 Identify the results for the pre-operative PFTs and indicate the percentage comparison to a normal value reference range of the volume of air that a patient can forcibly exhale from the lungs in one second **post-bronchodilator.**
42	FEV1/FVC pre-bronchodilator: (Pre- Bronchodilator FEV1/FVC Percentage Value)	☐☐%	3302955 Identify the results for the pre-operative PFTs and indicate the percentage value that represents the result of Forced Expiratory Volume in one second (FEV1) divided by the Forced Vital Capacity (FVC) **pre- bronchodilator.**
43	FEV1/FVC post-bronchodilator: (Post- Bronchodilator FEV1/FVC Percentage Value)	☐☐%	3302956 Identify the results for the pre-operative PFTs and indicate the percentage value that represents the result of Forced Expiratory Volume in one second (FEV1) divided by the Forced Vital Capacity (FVC) **post- bronchodilator.**
44	DLCO % REF: (Lung Carbon Monoxide Diffusing Capability Test Assessment Predictive Percentage Value)	☐☐☐%	2180255 Identify the results of the pre-operative PFTs and indicate the percentage value that represents the results of the patient's predicted DLCO. ***Note: If both the corrected and uncorrected DLCO values are available, record the corrected value.***
45	KRAS Mutation Gene Analysis Performed	☐ Yes ☐ No ☐ Unknown	3123147 Indicate if KRAS Mutation gene analysis was performed on the tumor submitted for TCGA. ***Note: If not performed, skip to EGFR Question.***
46	Mutation Found (KRAS)	☐ Yes ☐ No	2932340 If KRAS Mutation Gene Analysis was performed, indicate whether KRAS mutation was identified
47	If KRAS Mutation Identified, Which One	☐ G12A ☐ G12C ☐ G12D ☐ G12R ☐ G12S ☐ G12V ☐ G13D ☐ Other	3147614 If KRAS mutation was identified, indicate the specific mutation identified.
48	EGFR Mutation Status Assessed	☐ Yes ☐ No ☐ Unknown	3139429 Indicate if EGFR Mutation analysis was performed on the tumor submitted for TCGA. ***Note: If not performed, skip to EML4/ALK Question.***
49	If EGFR Mutation Identified, Which One	☐ G719X ☐ T790M ☐ L858R ☐ L861Q ☐ exon 19 Deletion ☐ exon 20 Insertion ☐ Other	3147627 If EGFR mutation analysis was performed, indicate the specific EGFR mutation identified.
50	EML4/ALK Translocation Status Assessed	☐ Yes ☐ No ☐ Unknown	3139437 Indicate if EML4/ALK Translocation status was assessed for the tumor submitted for TCGA. ***Note: If not assessed, skip to Vital Status Question.***
51	If EML4/ALK Translocation Found, Which Variant	☐ Variant 1 ☐ Variant 3 ☐ Variant 5 ☐ Variant 2 ☐ Variant 4	3139445 If EML4/ALK Translocation status was assessed, indicate the specific variant identified.
52	Method of EML4/ALK Analysis	☐ IHC ☐ RT-PCR ☐ FISH ☐ Other	3139449 If EML4/ALK Translocation status was assessed, indicate the analysis method utilized.

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Question#	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
Prognostic/Predictive/Lifestyle Factors (Used for Tumor Prognosis or Responsiveness to Treatment)			
53	Tobacco Smoking History Indicator	☐ Lifelong Non-smoker (<100 cigarettes smoked in Lifetime) ☐ Current smoker (includes daily smokers and non-daily smokers or occasional smokers) ☐ Current reformed smoker for > 15 years (greater than 15 years) ☐ Current reformed smoker for ≤15 years (less than or equal to 15 years) ☐ Current reformed smoker, duration not specified ☐ Smoking History not Documented	2181650 Indicate the patient's current smoking status or smoking history as self-reported by the patient.
54	Year of Onset of Tobacco Smoking	☐☐☐☐ (YYYY)	2228604 If the patient is a current or reformed smoker, indicate the year in which the patient began smoking.
55	Year of Quitting Tobacco Smoking	☐☐☐☐ (YYYY)	2228610 If the patient is a reformed smoker, indicate the year in which the patient quit smoking.
56	Number Pack Years Smoked	☐☐☐☐ 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.
57	Performance Status Score: Karnofsky Score	☐ 100 Normal, no complaints; no evidence of disease ☐ 90 Able to carry on normal activity; minor signs or symptoms of disease ☐ 80 Normal activity with effort; some signs or symptoms of disease ☐ 70 Cares for self; unable to carry on normal activity or to do active work ☐ 60 Requires occasional assistance; but is able to care for most of his/her needs ☐ 50 Requires considerable assistance and frequent medical care ☐ 40 Disabled; requires special care ☐ 30 Severely disabled ☐ 20 Very sick; requiring hospitalization ☐ 10 Moribund; fatal processes progressing rapidly ☐ 0 Dead ☐ Not Evaluated ☐ Unknown	2003853 Provide the patient's Karnofsky Score using the defined categories. This score represents the functional capabilities of the patient.
58	Performance Status Score: Eastern Cooperative Oncology Group	☐ 0 Asymptomatic ☐ 1 Symptomatic, but fully ambulatory ☐ 2 Symptomatic, in bed less than 50% of day ☐ 3 Symptomatic, in bed more than 50% of day, but not bed-ridden ☐ 4 Bed-ridden ☐ Not Evaluated	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.

		☐ Unknown	

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59	Performance Status Score: Timing	☐ Pre-Operative ☐ Other ☐ Pre-Adjuvant ☐ Unknown ☐ Post-Adjuvant ☐ Not Evaluated	2792763 Provide a time reference for the Karnofsky score and/or the ECOG score using the defined categories.
60	Adjuvant Post-operative Radiation Therapy	☐ Yes ☐ No ☐ 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.***
61	Adjuvant Post-operative Pharmaceutical Therapy	☐ Yes ☐ No ☐ 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***
62	Measure of Success of Outcome at the Completion of Initial First Course Treatment (surgery and/or adjuvant therapies)	☐ Not Evaluated ☐ Partial Response ☐ Progressive Disease ☐ Complete Response ☐ Stable Disease ☐ Unknown	2786727 Provide the patient's response to their initial first course treatment (surgery and/or adjuvant therapies).
New Tumor Event Information: Complete this section if the patient had a new tumor event after tissue procurement and prior to submission of the Enrollment Form. If the patient did not have a new tumor event, or if the TSS does not know, indicate this in the first question below; and then skip the remainder of this form.			
63	New Tumor Event After Initial Treatment?	☐ Yes ☐ No ☐ 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. ***Note: 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		☐ Not Applicable	
64	Month of New Tumor Event After Initial Treatment	☐☐ (MM)	3104044 If the patient had a new tumor event, provide the month of diagnosis for this new tumor event.
65	Day of New Tumor Event After Initial Treatment	☐☐ (DD)	3104042 If the patient had a new tumor event, provide the day of diagnosis for this new tumor event.
66	Year of New Tumor Event After Initial Treatment	☐☐☐☐ (YYYY)	3104046 If the patient had a new tumor event, provide the year of diagnosis for this new tumor event.
67	Number of Days from Date of Initial Pathologic Diagnosis to Date of New Tumor Event After Initial Treatment	_____	3392464 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 new tumor event after initial treatment. ***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	Type of New Tumor Event (check all that apply)	☐ Locoregional Recurrence ☐ Distant Metastasis ☐ New Primary Tumor	3119721 Indicate whether the patient's new tumor event was a locoregional recurrence or a distant metastasis of the tissue submitted for TCGA; or a new primary tumor.
69	Diagnostic Evidence of Recurrence / Relapse (check all that apply)	☐ Biopsy w/Histologic Confirmation ☐ Convincing Imaging (i.e. CT, PET, MRI) ☐ Positive Biomarker(s)	2786205 Indicate the procedure or testing method used to diagnose tumor recurrence or relapse.
70	Additional Surgery for New Tumor Event Loco-Regional Procedure	☐ Yes ☐ Unknown ☐ No	3008755 Using the patient's medical records, indicate whether the patient had surgery for the new loco-regional tumor event in question.

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Date of Additional Surgery for New Tumor Event Loco-regional		☐ Not Applicable (No Loco-regional Procedure for New Tumor Event)	
71	Month of Additional Surgery for New Tumor Event - Loco-Regional Procedure	☐☐ (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.
72	Day of Additional Surgery for New Tumor Event - Loco-Regional Procedure	☐☐ (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.
73	Year of Additional Surgery for New Tumor Event - Loco-Regional Procedure	☐☐☐☐ (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.
74	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 described on this form to the date of additional surgery for new tumor event (locoregional). ***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.***
75	Additional Surgery for New Tumor Event Metastasis Procedure	☐ Yes ☐ No ☐ 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		☐ Not Applicable (No Surgical Procedure for Metastatic Tumor Recurrence / Progression)	
76	Month of Additional Surgery for New Tumor Event Metastasis	☐☐ (MM)	2897038 If the patient had surgery for the new metastatic tumor event, provide the month of surgery for this new metastatic tumor event.
77	Day of Additional Surgery for New Tumor Event Metastasis	☐☐ (DD)	2897040 If the patient had surgery for the new metastatic tumor event, provide the day of surgery for this new metastatic tumor event.
78	Year of Additional Surgery for New Tumor Event Metastasis	☐☐☐☐ (YYYY)	2897042 If the patient had surgery for the new metastatic tumor event, provide the year of surgery for this new metastatic tumor event.
79	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event – Metastasis	_____	3408682 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 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.***
80	Additional Treatment of New Tumor Event Radiation Therapy	☐ Yes ☐ No ☐ Unknown	3008761 Indicate whether the patient received radiation treatment for this new tumor event.
81	Additional Treatment of New Tumor Event Pharmaceutical Therapy	☐ Yes ☐ No ☐ Unknown	2650646 Indicate whether the patient received pharmaceutical treatment for this new tumor event.

Comments:

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_____

Principal Investigator Name: _____ Principal Investigator Signature: _____

Date Signed (MM/DD/YYYY): _____