Enrollment Form
Sarcoma (SARC)

Instructions: *The 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 and known history from the date of initial diagnosis to the most recent date of contact with the patient ("Date of Initial Pathologic Diagnosis" and "Date of Last Contact" on this form).*

Questions regarding this form should be directed to the Tissue Source Site's primary Clinical Outreach Contact at the BCR.

Please note the following definitions for the "Unknown" and "Not Evaluated" answer options on this form.

Unknown: This answer option should only be selected if the TSS does not know this information after all efforts to obtain the data have been exhausted. 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 a reason why the answer is unknown.

Not Evaluated: This answer option should only be selected by the TSS if it is known that the information being requested cannot be obtained. This could be because the test in question was never performed on the patient or the TSS knows that the information requested was never disclosed.

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

Completed By *(Interviewer Name in OpenClinica)*: _____ Completed Date: _____

General Information

#	Data Element	Entry Alternatives	Working Instructions
1	Is this a prospective tissue collection?	☐ Yes ☐ No	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. 3088492
2	Is this a retrospective tissue collection?	☐ Yes ☐ No	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. 3088528
Patient Information			
Date of Birth			
3	Month of Birth	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	Provide the month the patient was born. 2896950
4	Day of Birth	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	Provide the day the patient was born. 2896952
5	Year of Birth	_____	Provide the year the patient was born. 2896954
6	Gender	☐ Female ☐ Male	Provide the patient's gender using the defined categories. 2200604
7	Race	☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander: ☐ Not Evaluated ☐ Unknown	Provide the patient's race using the defined categories. 2192199 American Indian or Alaska Native: *A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.* Asian: *A person having origins in any of the original peoples of the far East, Southeast Asia, or in the Indian subcontinent including, for example, 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 the far Europe, the Middle East, or North Africa.* Black or African American: *A person having origins in any of any of the 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 of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.* Not Evaluated: *Not provided or available.* Unknown: *Could not be determined or unsure.*

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8	Ethnicity	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Not Evaluated ☐ Unknown	Provide the patient's ethnicity using the defined categories. 2192217 Not Hispanic or Latino: *A person not meeting the definition of 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.*
9	History of Other Malignancy	☐ Yes ☐ No	Indicate whether the patient was, at any time in their life, diagnosed with a malignancy prior to the diagnosis of the specimen submitted for TCGA. If the patient has had a prior malignancy, an additional form (the "Other Malignancy Form") must be completed for each prior malignancy. If the OMF was completed and submitted with the Initial Case Quality Control Form, the OMF does not need to be submitted a second time. 3382736 *Note: Samples from patients who received treatment for a prior malignancy greater than 3 years before the procurement of the submitted sample are eligible for submission. If this question cannot be answered because the answer is unknown, the case will be excluded from TCGA. If the patient has a history of multiple diagnoses of basal or squamous cell skin cancer, complete an OMF for the first diagnosis for each of these types.
10	History of Neo-adjuvant Treatment ***for Sample Submitted for TCGA***	☐ Yes ☐ No	Indicate whether the patient received neo-adjuvant treatment (radiation, pharmaceutical, or both) prior to the collection of the tumor that yielded the sample submitted for TCGA. 3382737 Systemic therapy and certain localized therapies (those administered to the same site as the TCGA submitted tissue) given prior to the collection of the sample submitted for TCGA is exclusionary.
11	Tumor Status *(at time of last contact or death)*	☐ Tumor free ☐ With tumor ☐ Unknown	Indicate whether the patient was tumor/disease free at the date of last contact or death. 2759550
12	Vital Status *(at date of last contact)*	☐ Living ☐ Deceased	Indicate whether the patient was living or deceased at the date of last contact. 2939553
13	Month of Last Contact	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	If the patient is living, provide the month of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897020 Do not answer if patient is deceased.
14	Day of Last Contact	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	If the patient is living, provide the day of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897022 Do not answer if patient is deceased.
15	Year of Last Contact	_____	If the patient is living, provide the year of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897024 Do not answer if patient is deceased.
16	Month of Death	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	If the patient is deceased, provide the month of death. 2897026
17	Day of Death	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	If the patient is deceased, provide the day of death. 2897028

18	Year of Death	_____	If the patient is deceased, provide the year of death. 2897030
19	Adjuvant (Post-Operative) Radiation Therapy	☐ Yes ☐ No	Indicate whether the patient had adjuvant/ post-operative radiation therapy. 2005312 If the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.
20	Adjuvant (Post-Operative) Pharmaceutical Therapy	☐ Yes ☐ No	Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy. 2785850 If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.

Primary Tumor Pathologic/ Prognostic Information

#	Data Element	Entry Alternatives	Working Instructions
21	Histological Type	☐ Dedifferentiated liposarcoma ☐ Leiomyosarcoma (LMS)* ☐ Undifferentiated Pleomorphic Sarcoma (UPS), NOS ☐ Pleomorphic 'MFH'/ Undifferentiated pleomorphic sarcoma ☐ Giant cell 'MFH' / Undifferentiated pleomorphic sarcoma with giant cells ☐ Inflammatory 'MFH' / Undifferentiated pleomorphic sarcoma with prominent inflammation ☐ Malignant Peripheral Nerve Sheath Tumors (MPNST) ☐ Desmoid Tumor ☐ Myxofibrosarcoma (≥10%) ☐ Synovial Sarcoma ☐ Monophasic ☐ Biphasic ☐ Poorly differentiated	Using the patient's pathology/laboratory report, select the histological type of the tumor submitted for TCGA. 3081934 If the histological type is Leiomyosarcoma, please complete the three additional questions below. For other histological subtypes these questions can be skipped.
22	Leiomyosarcoma: Histological Subtype	☐ Well-differentiated leiomyosarcoma (resembling leiomyoma) ☐ Conventional leiomyosarcoma ☐ Poorly differentiated/ pleomorphic/ epithelioid leiomyosarcoma	If the histological subtype is Leiomyosarcoma, using the patient's pathology/laboratory report, select the histological subtype of the tumor submitted for TCGA. 2831122
23	Leiomyosarcoma: Uterine Involvement	☐ Yes ☐ No ☐ Unknown	If the histological subtype is Leiomyosarcoma, using the patient's pathology/ laboratory report, indicate whether there was uterine involvement. 2775554
24	Leiomyosarcoma: Major Vessel Involvement	☐ No ☐ Unknown ☐ Yes ☐ Jugular/carotid ☐ Subclavicular ☐ Superior vena cava/chest ☐ Inferior vena cava ☐ Brachial vein/ axillary vein ☐ Pelvic vein/ common/external/ iliac ☐ Common/ superficial femoral vein ☐ Renal vein	If the histological subtype is Leiomyosarcoma, using the patient's pathology/ laboratory report, indicate whether there was major vessel involvement. If the patient did have major vessel involvement, indicate where it was located. 3243330
25	Synovial Sarcoma: SS18-SSX Fusion Status	☐ Positive ☐ SS18-SSX1 ☐ SS18-SSX2 ☐ Subtype ☐ Negative ☐ Unknown	Using the patient's pathology/cytogenetics/molecular diagnostics laboratory report, indicate whether evidence of an SS18-SSX fusion was reported and the testing method. 3733516

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#	Data Element	Entry Alternatives	Working Instructions
26	Synovial Sarcoma: SS18-SSX Testing Method	☐ RT-PCR ☐ FISH for SS18 split ☐ Both ☐ Unknown	Using the patient's pathology/cytogenetics/molecular diagnostics laboratory report, indicate the testing method for SS18-SSX. 3733517
27	MPNST: Does the patient have neurofibrobromatosis?	☐ NF1 ☐ NF2 ☐ No ☐ Unknown	Using the patient's medical records, indicate whether the patient had neurofibrobromatosis. 3733521
28	MPNST: If the patient has neurofibrobromatosis, is it familial or sporadic?	☐ Familial ☐ Sporadic ☐ Unknown	If the patient had neurofibromatosis, indicate if it was known to be familial or sporadic. 3733535
29	MPNST: Pre-exisiting plexiform neurofibroma at site of MPNST?	☐ Yes ☐ No ☐ Unknown	Using the patient's medical records, indicate whether the patient had pre-exisiting plexiform neurobibroma at site of MPNST. 3733551
30	MPNST: Was NF1 Genetic Testing Performed?	☐ Yes, mutations identified ☐ Yes, mutations were NOT identified ☐ No ☐ Unknown	Using the patient's medical records, indicate whether NF1 genetic testing was performed. 3733556
31	MPNST: If NF1 genetic testing was performed and mutations were identified, please identify the specific mutations.	_____	If NF1 genetic testing was performed, provide any specific mutations that were identified. 3733558
32	Tumor Depth	☐ Superficial ☐ Deep ☐ Unknown	Using the patient's pathology/ laboratory report, indicate the depth of the tumor. 3243362
33	Primary Site of Disease	☐ Head & Neck ☐ Head ☐ Neck ☐ Other, specify ☐ Chest ☐ Lung/pleura ☐ Mediastinum ☐ Chest wall ☐ Diaphragm ☐ Breast ☐ Other, specify ☐ Superficial Trunk ☐ Abdominal wall ☐ Buttock ☐ Flank ☐ Back ☐ Other, specify ☐ Upper Extremity ☐ Shoulder/axilla ☐ Upper arm/elbow ☐ Forearm ☐ Hand/wrist ☐ Other, specify ☐ Lower Extremity ☐ Thigh/knee ☐ Groin ☐ Lower leg/calf ☐ Foot/ankle ☐ Other, specify ☐ Retroperitoneum/ Upper abdominal ☐ Retroperitoneum ☐ Intraabdominal ☐ Kidney ☐ Liver ☐ Colon ☐ Gastric ☐ Duodenum ☐ Small Intestines ☐ Pancreas ☐ Other, specify ☐ Lower abdominal/ Pelvic ☐ Pelvic ☐ Bladder ☐ Prostate ☐ Rectum ☐ Spermatic Cord ☐ Scrotum/testis ☐ Other, specify ☐ Gynecological ☐ Uterus ☐ Ovary ☐ Cervix ☐ Fallopian tube ☐ Other, specify	Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for TCGA. 2735776 If the histological type is Leiomyosarcoma and the primary site of disease is skin, this case is excluded.
34	Other Primary Site of Disease	_____	If the primary site of disease on the pathology/laboratory report is not available or does not specifically match the provided sites above, describe the site(s) of disease. 2584114
35	Month of Initial Pathologic Diagnosis	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	Provide the month the patient was initially diagnosed with the malignancy submitted for TCGA. 2896956

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#	Data Element	Entry Alternatives	Working Instructions
36	Day of Initial Pathologic Diagnosis	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	Provide the day the patient was initially diagnosed with the malignancy submitted for TCGA. 2896958
37	Year of Initial Pathologic Diagnosis	_____	Provide the year the patient was initially diagnosed with the malignancy submitted for TCGA. 2896960
38	Margin Status	☐ Positive (+) *≤ 1mm* ☐ Negative (-) ☐ Unknown	Provide the margin status after the patient's first surgical procedure. 3114007
39	Residual Tumor	☐ RX ☐ R1 ☐ R0 ☐ R2	Using the patient's pathology/laboratory report, select the residual tumor status after the surgical resection. 2608702
40	Necrosis of Total Tumor	☐ 0% *(no necrosis or no mention of necrosis)* ☐ <10% *("focal necrosis")* ☐ Moderate Necrosis *(≥10, <50%)* ☐ Extensive Necrosis *(>50%)* ☐ Complete or if listed *(>99% or profound therapy effect)*	Using the patient's pathology/laboratory report, select the necrosis of the total tumor. If a specific percentage of necrosis is available, answer the following question. 3300612
41	Percent Necrosis of Total Tumor	_____	Indicate the percent necrosis of the entire tumor as recorded either at the time of resection or during subsequent analysis. 2841237
42	Mitotic Count	_____ (number mitoses per 10 high power fields)	Using the patient's pathology/laboratory report, provide the patient's mitotic count. This should be the number mitoses per 10 high powered fields (10 HPF ≅ 2.2 mm^2). 3227319
43	Is Disease Multifocal?	☐ Yes ☐ No ☐ Unknown	Using the patient's pathology/laboratory report, indicate whether the disease was multifocal. 64356
44	Number of Discontiguous Lesions	_____	Using the patient's pathology/laboratory report, provide the number of discontiguous lesions. 3162604

Tumor Size: Include both well-differentiated and de-differentiated components.
(If there were multiple lesions, complete this question for each lesion)

45	Radiologic Tumor Size	Radiologic Length	_____ (cm)	Provide the length for this tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection. 3528021
		Radiologic Width	_____ (cm)	Provide the width for this tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection. 3528033
		Radiologic Depth	_____ (cm)	Provide the depth for this tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection. 3528032
46	Pathologic Tumor Size	Pathologic Length	_____ (cm)	Provide the length for this tumor, when available as examined pathologically at the time of the surgical resection. 3528034
		Pathologic Width	_____ (cm)	Provide the width for this tumor, when available as examined pathologically at the time of the surgical resection. 3528041
		Pathologic Depth	_____ (cm)	Provide the depth for this tumor, when available as examined pathologically at the time of the surgical resection. 3528040
47	Radiologic Tumor Burden	_____		Provide the sum of the maximum diameter of the primary tumors as reported on the CT scan or MRI immediately preceding surgical resection. This should include both well-differentiated and de-differentiated components. 3162636
48	Pathologic Tumor Burden	_____		Provide the sum of the maximum diameter of the primary tumors as examined pathologically at the time of the surgical resection. This should include both well-differentiated and de-differentiated components. 3162641

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#	Data Element	Entry Alternatives	Working Instructions
49	Locoregional Recurrence	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had a local recurrence associated with the tumor submitted for TCGA. 62652
50	Metastasis *(Radiologic Evidence)*	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient was diagnosed with a distant metastasis with radiologic evidence. 65384
51	Location of Metastasis	☐ Lung ☐ Bone ☐ Liver ☐ Unknown ☐ Other, specify	If the patient had a metastatic tumor associated with the diagnosis of the tumor submitted for TCGA, provide the site of the metastasis. If there was more than one metastatic site, select all that apply. 62835
52	Other Location of Metastasis	_____	If the site of the metastasis was not included in the list provided, please provide the site. 3135371
53	Contiguous Organ/ Structure Resection	☐ Adrenal ☐ Bladder ☐ Colon ☐ Inferior vena cava (IVC) ☐ Kidney ☐ Liver ☐ Small Bowel ☐ Spleen ☐ Unknown ☐ Other, specify	If the patient had a contiguous organ/ structure removed, indicate the location of the contiguous organ. 3162811
54	Other Contiguous Organ/ Structure Resection	_____	If the site of the contiguous organ/ structure was not included in the list provided, describe the organ. 3162812
55	Contiguous Organ Invaded	☐ Yes ☐ No ☐ Unknown	Indicate whether the tumor invaded a contiguous organ. 3162817
56	Dedifferentiated Liposarcoma: Prior Diagnosis of Well Differentiated Liposarcoma	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had a prior diagnosis of well differentiated liposarcoma. 3162681 Only answer this question if the histological subtype for tumor submitted to TCGA is dedifferentiated liposarcoma. All other subtypes can skip the remaining questions.
Date of Primary Diagnosis of Well Differentiated Liposarcoma			
57	Month Primary Diagnosis of Well Differentiated Liposarcoma	☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10 ☐ 11 ☐ 12	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the month of this diagnosis. 3162688
58	Day Primary Diagnosis of Well Differentiated Liposarcoma	☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the day of this diagnosis. 3162689
59	Year Primary Diagnosis of Well Differentiated Liposarcoma	_____	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the year of this diagnosis. 3162690
Date of Resection of Well Differentiated Liposarcoma			
60	Month Resection of Well Differentiated Liposarcoma	☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10 ☐ 11 ☐ 12	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the month the tumor was removed. 3162705
61	Day Resection of Well Differentiated Liposarcoma	☐ 01 ☐ 02 ☐ 03 ☐ 04 ☐ 05 ☐ 06 ☐ 07 ☐ 08 ☐ 09 ☐ 10 ☐ 11 ☐ 12 ☐ 13 ☐ 14 ☐ 15 ☐ 16 ☐ 17 ☐ 18 ☐ 19 ☐ 20 ☐ 21 ☐ 22 ☐ 23 ☐ 24 ☐ 25 ☐ 26 ☐ 27 ☐ 28 ☐ 29 ☐ 30 ☐ 31	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the day the tumor was removed. 3162706
62	Year Resection of Well Differentiated Liposarcoma	_____	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the year the tumor was removed. 3162707

New Tumor Event Information *Complete this section if the patient had a new tumor event. If the patient did not have a new tumor event (or if the TSS does not know) indicate this in the question below, and the remainder of this section can be skipped.*

Note: The New Tumor Event section on OpenClinica can be completed multiple times, if the patient had multiple New Tumor Events.

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#	Data Element	Entry Alternatives	Working Instructions
63	New Tumor Event After Initial Treatment?	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after the date of initial diagnosis. 3121376
64	Type of New Tumor Event	☐ Locoregional/Recurrence ☐ Distant Metastasis ☐ New Primary Tumor	Indicate whether the patient's new tumor event was a locoregional recurrence, a distant metastasis or a new primary tumor. 3119721
65	Site of New Tumor Event	☐ Lung ☐ Bone ☐ Liver ☐ Other, specify	Indicate the site of this new tumor event. 3108271
66	Other Site of New Tumor Event	_____	If the patient had a new tumor event and the site of this tumor was not included in the provided list, describe the site. 3128033
Date of New Tumor Event after Initial Treatment			
67	Month of New Tumor Event	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	If the patient had a new tumor event, provide the month of diagnosis for this new tumor event. 3104044
68	Day of New Tumor Event	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	If the patient had a new tumor event, provide the day of diagnosis for this new tumor event. 3104042
69	Year of New Tumor Event	_____	If the patient had a new tumor event, provide the year of diagnosis for this new tumor event. 3104046
70	Additional Surgery for New Tumor Event	☐ Yes ☐ No ☐ Unknown	Using the patient's medical records, indicate whether the patient had surgery for the new tumor event in question. 3427611
Date of Additional Surgery for New Tumor Event (when applicable)			
71	Month of Additional Surgery for New Tumor Event	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	If the patient had surgery for the new tumor event, provide the month this surgery was performed. 3427612
72	Day of Additional Surgery for New Tumor Event	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	If the patient had surgery for the new tumor event, provide the day this surgery was performed. 3427613
73	Year of Additional Surgery for New Tumor Event	_____	If the patient had surgery for the new tumor event, provide the year this surgery was performed. 3427614
74	Residual Tumor after Surgery for New Tumor Event	☐ RX ☐ R1 ☐ R0 ☐ R2	Using the patient's pathology/laboratory report, select the residual tumor status after the surgical resection for the new tumor event. 3104061
75	Is the New Disease Multifocal?	☐ Yes ☐ No	Using the patient's pathology/laboratory report, indicate whether the new tumor was multifocal. 3524937
76	Number of Discontiguous Lesions (New Tumor Event)	_____	Using the patient's pathology/laboratory report, provide the number of discontiguous lesions for the new tumor. 3526717
77	Radiologic Burden of New Tumor	_____	Provide the sum of the maximum diameter of the new tumors as reported on the CT scan or MRI immediately preceding surgical resection. This should include both well-differentiated and de-differentiated components. 3562720

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#	Data Element	Entry Alternatives		Working Instructions
78	Pathologic Burden of New Tumor	_____		Provide the sum of the maximum diameter of the new tumors as examined pathologically at the time of the surgical resection. This should include both well-differentiated and de-differentiated components. 3526721
79	Is the New Tumor Well-Differentiated or De-Differentiated? *(Check all that apply)*	☐ Well-Differentiated ☐ De-Differentiated		Indicate whether the newly diagnosed tumor is well-differentiated or de-differentiated. 3194001
80	Additional treatment for New Tumor Event: *Radiation Therapy*	☐ Yes ☐ No ☐ Unknown		Indicate whether the patient received radiation treatment for this new tumor event. 3427615
81	Additional treatment for New Tumor Event: *Pharmaceutical Therapy*	☐ Yes ☐ No ☐ Unknown		Indicate whether the patient received pharmaceutical treatment for this new tumor event. 3427616
82	Radiologic Size of New Tumor	Radiologic Length	_____ (cm)	Provide the length for the new tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection of the new tumor. 3527990
		Radiologic Width	_____ (cm)	Provide the width for the new tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection of the new tumor. 3527997
		Radiologic Depth	_____ (cm)	Provide the depth for the new tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection of the new tumor. 3527996
83	Pathologic Size of New Tumor	Pathologic Length	_____ (cm)	Provide the length for the new tumor, when available as examined pathologically at the time of the surgical resection of the new tumor. 3528003
		Pathologic Width	_____ (cm)	Provide the width for the new tumor, when available as examined pathologically at the time of the surgical resection of the new tumor. 3528020
		Pathologic Depth	_____ (cm)	Provide the depth for the new tumor, when available as examined pathologically at the time of the surgical resection of the new tumor. 3528004

_____

Principal Investigator Signature Date

I acknowledge that the above information provided by my institution is true and correct and has been quality controlled.