Enrollment Form

Burkitt Lymphoma Genome Sequencing Project (BLGSP)

Instructions: *The Clinical Data needed to complete this Enrollment Form should be collected for each patient in the Burkitt Lymphoma Genome Sequencing Project (BLGSP)* prior *to acquisition of tissues. Upon qualification notice from the Office of Cancer Genomics (OCG), the Tissue Source Site (TSS) should complete this Enrollment form for each qualified case within 60 days.*

Questions regarding this form should be directed to the Nationwide Children's Hospital (NCH) or OCG.

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 BLGSP 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: _____

#	Data Element	Entry Alternatives	Working Instructions
General Information			
BLGSP Project ID:			
*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 after the date the BLGSP contract was executed, 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 BLGSP contract was executed, the tissue has been collected retrospectively. 3088528
Patient Information			
Demographic Information			
*3	Date of Birth	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date the patient was born. 2896950 (month), 2896952 (day), 2896954 (year) *Note: The day of Birth is not required.*
*4	Gender	☐ Female ☐ Male	Provide the patient's gender using the provided categories. 2200604
*5	Race *(check all that apply)*	☐ American Indian or Alaska Native ☐ Asian/East Indian ☐ White ☐ Black/African American ☐ Native Hawaiian or other Pacific Islander ☐ 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 four 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. Unknown: Could not be determined or unsure
6	Ethnicity	☐ Not Hispanic or Latino ☐ Hispanic or Latino ☐ Not Reported ☐ 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 Reported: Not provided or available Unknown: Could not be determined or unsure
7	Height *(at time of diagnosis)*	_____(cm)	Provide the patient's height (centimeters) at the time the patient was diagnosed with the tumor submitted for BLGSP. 649
8	Weight *(at time of diagnosis)*	_____(kg)	Provide the patient's weight (kilograms) at the time the patient was diagnosed with the tumor submitted for BLGSP. 651
Survival Information			
*9	Vital Status *(at date of last contact)*	☐ Living ☐ Deceased	The survival state of the person registered on the protocol. 5

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*11	Date of Last Known Alive	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Indicate the last date the patient was known to be alive, regardless of whether the patient, medical provider, family member or caregiver was contacted. 2975722 (month), 2975724 (day), 2975726 (year) *Note: The day of Last Known Alive is not required.*
†10	Date of Last Contact	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	If the patient is living, provide the date of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897020 (month), 2897022 (day), 2897024 (year) *Note: The day of Last Contact is not required.* *Do not answer if patient is deceased.*
†12	Date of Death	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	If the patient is deceased, provide the month of death. 2897026, (month) 2897028 (day), 2897030 (year) *Note: The day of Death is not required.*
13	Cause of Death Only complete if patient is deceased.	☐ Cancer Related ☐ Non-Cancer Related ☐ Unknown ☐ Other (please specify)	Indicate the patient's cause of death. 2554674
14	Other Cause of Death Only complete if "other" is selected above.	_____	If the patient's cause of death was not included in the provided list, specify the patient's cause of death. 2004150
Patient Status (Regarding Submitted Tumor)			
*15	Did the patient receive neo-adjuvant therapy for the tumor submitted for BLGSP?	☐ Yes *(exclusion criterion)* ☐ No	Indicate whether the patient received treatment (radiation, pharmaceutical, or both) prior to the procurement of the sample submitted for BLGSP. 3382737 *If the answer to this question is "yes", the submitted case is excluded.*
*16	Tumor Status *(at time of last contact or death)*	☐ Tumor free ☐ With tumor ☐ Unknown	Indicate whether the patient was tumor/disease free (i.e. free of the malignancy that yielded the sample submitted for the BLGSP study) at the date of last contact or death. 2759550
17	Performance Status: Eastern Cooperative Oncology Group (at diagnosis)	☐ 0: Fully active, able to carry on all pre-disease performance without restriction. ☐ 1: Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work. ☐ 2: Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours. ☐ 3: Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours. ☐ 4: Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair. ☐ Unknown ☐ Not Evaluated	Provide the Eastern Cooperative Oncology Group (ECOG) performance status of the patient at the time selected in the "timing" question below. 88
18	Performance Status: Karnofsky Score (at diagnosis)	☐ 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 and assistance ☐ 30: Severely disabled, hospitalization indicated. Death not imminent. ☐ 20: Very sick, hospitalization indicated. Death not imminent. ☐ 10: Moribund, fatal processes progressing rapidly ☐ 0: Dead ☐ Unknown ☐ Not Evaluated	Provide the Karnofsky score for the patient at the time selected in the "timing" question below. 2003853
19	Tumor Response	☐ Progressive Disease ☐ Stable Disease ☐ Partial Response ☐ Complete Response	Indicate the patient's measure of success after their primary treatment for the tumor submitted. Treatment includes surgery and adjuvant therapies. 2786727

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20	Adjuvant (Post-Operative) Radiation Therapy	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had adjuvant/ post-operative radiation therapy *for the tumor submitted.* 2005312
21	Adjuvant (Post-Operative) Pharmaceutical Therapy	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy *for the tumor submitted*. 3397567
Patient History of Disease			
HIV Status			
*22	Is this patient HIV positive?	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient is HIV positive. 2180464
†23	Date of HIV Diagnosis (if known) Only complete if "Yes" is selected above.	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the month the patient was diagnosed with HIV. 3579640 (month), 3579644 (day), 3579643 (year) *Note: The day of HIV Diagnosis is not required.*
24	Nadir CD4 Counts *(at time of last contact)*	_____ (cells/mm^3)	Provide the patient's Nadir CD4 counts, which are the lowest CD4 counts the patient has had. 2684395
25	CD4 Counts at Diagnosis of the Submitted Malignancy	_____ (cells/mm^3)	Provide the patient's CD4 Counts at the time the patient was diagnosed with the malignancy submitted for the BLGSP study. 2922654
26	HIV RNA load at Diagnosis of Submitted Malignancy	_____ (counts/mL)	Provide the HIV RNA load (also known as the "viral load") at the time the patient was diagnosed with the malignancy submitted for the BLGSP study. 2922674
27	Prior AIDS Defining Conditions	☐ Candidiasis of bronchi, trachea or lungs ☐ Candidiasis, esophageal ☐ CMV other than liver, spleen or nodes, onset at age >1month ☐ CMV retinitis ☐ Coccidioidomycosis, disseminated or extrapulmonary ☐ Cryptococcosis, extrapulmonary ☐ Cryptosporidiosis, chronic intestinal ☐ Encephalopathy, HIV-related ☐ Herpes simplex: chronic ulcers (> 1 month's duration) or bronchitis, pneumonitis or esophagitis (onset at age > 1 month) ☐ Histoplasmosis, disseminated or extrapulmonary ☐ Isosporiasis, chronic intestinal (> 1 mon) ☐ Mycobacterium avium complex or Mycobacterium kansasii disseminated or extrapulmonary ☐ Mycobacterium tuberculosis of any site, pulmonary, disseminated or extrapulmonary ☐ Mycobacterium; other species or unidentified species, disseminated or extrapulmonary ☐ Nocardiosis ☐ Pneumocystis jirovecii pneumonia ☐ Pneumonia, recurrent ☐ Progressive multifocal leukoencephalopathy ☐ Salmonella septicemia, recurrent ☐ Toxoplasmosis of the brain, onset at age >1month ☐ Wasting syndrome, due to HIV	Prior to the malignancy submitted for the BLGSP study, provide any AIDS defining conditions. 2679581
28	Co-Infections	**Test** / **(+)** / **(-)** / **Inconclusive** / **Not Tested**	Using the list provided, indicate whether the patient had any co-infections by providing the results of each of the tests listed.
		HBV ☐ ☐ ☐ ☐	2180456
		HCV ☐ ☐ ☐ ☐	2695021
		HPV ☐ ☐ ☐ ☐	2230033
		KSHV/ HHV8 ☐ ☐ ☐ ☐	3335773
29	HAART Treatment Prior to Diagnosis of Submitted Malignancy	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient received Highly Active Antiretroviral Therapy (HAART) treatment prior to the diagnosis of the malignancy submitted for the BLGSP study. 3335156

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30	HAART Treatment at Time of Diagnosis of Submitted Malignancy	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient received Highly Active Antiretroviral Therapy (HAART) treatment at the time of the diagnosis of the malignancy submitted for the BLGSP study. 2922679
31	CDC HIV Risk Group	☐ Homosexual or bisexual contact ☐ Heterosexual contact ☐ IV drug user ☐ Transfusion recipient ☐ Hemophiliac ☐ None ☐ Unknown	Indicate whether the patient has a history of any of the listed HIV Risk Groups as defined by the Center for Disease Control (CDC). 2542215
Prior Malignancies			
*32	History of other malignancy	☐ Yes *(exclusion criterion)* ☐ No	Indicate whether the patient has a history of malignancies, including synchronous or bilateral malignancies. 3382736 *If the answer to this question is "yes", the submitted case is excluded. This exclusion does not apply if the patient only has a history of non-melanoma skin cancer OR cervical in situ carcinoma.*
Prior Immunological Disease			
33	Patient History of Prior Immunological Disease	☐ Rheumatoid Arthritis ☐ Sjogren's Syndrome ☐ Systemic Lupus Erythematosus ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ Hashimoto's Thyroiditis ☐ None ☐ Other ☐ Unknown	Indicate whether the patient has a history of any of the listed immunological diseases. 3233628
34	Patient History of Other Immunological Disease Only complete if "other" is selected above.	_____	Indicate whether the patient has a history of any of the listed immunological diseases. 3233629
35	Patient History of Prior Immunosuppressive Therapy for Immunological Disease	☐ Methotrexate ☐ Cyclophosphamide ☐ Azathioprine ☐ Anti-TNF therapy ☐ None ☐ Other ☐ Unknown	If the patient received immunosuppressive therapy for the immunological disease selected in the previous question, provide the type of immunosuppressive therapy given. 3233638
36	Other History of Prior Imunosuppressive Therapy Only complete if "other" is selected above.	_____	What was the other immunosuppressive therapy administered? 2873928
Prior Infectious Disease			
37	Patient History of Relevant Prior Infectious Disease	☐ Hepatitis B ☐ Hepatitis C ☐ H. Pylori ☐ Malaria ☐ None ☐ Other ☐ Unknown	Indicate whether the patient has a history of any of the listed infectious disease. 3233642
38	Patient History of Other Relevant Infectious Disease Only complete if "other" is selected above.	_____	If the patient has a history of relevant prior disease that was not included in the list, provide the infectious disease. 3233643
Pathologic Information			
*39	Histological Subtype	☐ Burkitt Lymphoma (BL), classic morphology ☐ Burkitt Lymphoma (BL), atypical morphology ☐ B-cell lymphoma, unclassifiable, with features intermediate between diffuse large B-cell lymphoma and Burkitt lymphoma ☐ Diffuse large B-cell lymphoma (DLBCL), specify subtype [e.g. NOS, plasmablastic] ☐ Unclassifiable B-cell lymphoma ☐ Other, specify ☐ Unknown	Using the patient's final diagnostic pathology report, provide the most detailed histological subtype available. 3081934
†40	Other Neoplasm Histologic Type, Specify Only complete if "other" is	_____	Free text field to specify the structural pattern of cancer cells used to define a microscopic diagnosis that is not already specified or mentioned.

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#	Data Element	Entry Alternatives	Working Instructions
	selected above.		3294805
*41	Site(s) of Nodal Involvement at Diagnosis *(Please check all that apply)*	☐ Axillary ☐ Cervical ☐ Epitrochlear ☐ Femoral ☐ Hilar ☐ Iliac ☐ Iliac-common ☐ Iliac-external ☐ Inguinal ☐ Mediastinal ☐ Mesenteric ☐ Occipital ☐ Paraaortic ☐ Parotid ☐ Popliteal ☐ Retroperitoneal ☐ Splenic ☐ Supraclavicular ☐ Submandibular ☐ No known nodal involvement	Using the patient's medical record check all applicable boxes to identify the lymph node chain(s) that were involved by Burkitt lymphoma at the time of initial diagnosis. 2180591 *To select multiple sites of involvement, press the control button and select the sites of involvement. Your selections should be highlighted after you've selected.*
42	Extranodal Involvement At Diagnosis?	☐ Yes ☐ No ☐ Unknown	2952463
43	Number of Extranodal Sites of Involvement Above *(to calculate the IPI)*	_____	Provide the total number of extranodal sites with lymphoma involvement. Use the previous three questions to determine this number. This information, along with other data provided, will be used by the Analysis Working Group (AWG) to calculate the International Prognostic Index (IPI). 3233242
†44	Site(s) of Extranodal Involvement At Diagnosis *(For Primary Clinical Involvement at Time of Diagnosis - Please check all that apply)* Only complete if "yes" is selected above.	☐ Adrenal Gland ☐ Bone ☐ Bone Marrow ☐ Breast ☐ Neck ☐ Peripheral Blood ☐ Skin ☐ Soft Tissue *(muscle, ligaments, subcutaneous)* **ENT & Eye** ☐ Eye ☐ Larynx ☐ Mandible ☐ Maxilla ☐ Nasal Soft Tissue ☐ Nasopharynx ☐ Ocular orbits ☐ Oropharynx ☐ Parotid Gland ☐ Peri-orbital Soft Tissue ☐ Salivary Gland ☐ Sinus(es) ☐ Thyroid gland **Central Nervous System** ☐ Brain ☐ Cerebrospinal Fluid ☐ Epidural space ☐ Leptomeninges **Gastrointestinal/ Abdominal** ☐ Ascites ☐ Appendix ☐ Colon ☐ Esophagus ☐ Gallbladder ☐ Liver ☐ Pancreas ☐ Rectum ☐ Small Intestine ☐ Stomach **Genito-urinary Tract** ☐ Bladder ☐ Epididymis ☐ Kidney ☐ Ovary ☐ Prostate ☐ Testicle ☐ Uterus **Mediastinal/ Intra-thoracic** ☐ Heart ☐ Lung ☐ Mediastinal Soft Tissue ☐ Pericardium ☐ Pleura ☐ Not applicable ☐ Other, please specify	Using the patient's medical record check all applicable boxes to identify the anatomic location of all site(s) of extranodal involvement by Burkitt lymphoma at the time of initial diagnosis. 3288482 *To select multiple sites of involvement, press the control button and select the sites of involvement. Your selections should be highlighted after you've selected.*
†45	Other Specified Site of Extranodal Involvement at Diagnosis *(For Primary Clinical Involvement)* Only complete if "other" is selected above.	_____	If all extranodal sites of involvement are not included in the list provided, please indicate any sites of extranodal involvement. 3234303
46	Maximum Tumor Bulk *(Dimension)*	_____ (cm)	After review of the entire medical record, record the length of the largest dimension/ diameter of a tumor, regardless of anatomical plane. 64215

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#	Data Element	Entry Alternatives	Working Instructions
*47	Anatomic Site of Maximum Tumor Bulk	☐ Adrenal ☐ Bone ☐ Bone Marrow ☐ Breast ☐ Neck ☐ Peripheral Blood ☐ Skin ☐ Soft Tissue *(muscle, ligaments, subcutaneous)* **Genito-urinary Tract** ☐ Bladder ☐ Epididymis ☐ Kidney ☐ Ovary ☐ Prostate ☐ Testes ☐ Uterus **ENT & Eye** ☐ Eye ☐ Larynx ☐ Mandible ☐ Maxilla ☐ Nasal Soft Tissue ☐ Nasopharynx ☐ Ocular Orbits ☐ Oropharynx ☐ Parotid Gland ☐ Peri-orbital Soft Tissue ☐ Salivary Gland ☐ Sinus ☐ Thyroid **Mediastinal/ Intra-thoracic** ☐ Heart ☐ Lung ☐ Mediastinal Soft Tissue ☐ Pericardium ☐ Pleura ☐ Not applicable ☐ Other ☐ No Known Extranodal Involvement **Gastrointestinal/ Abdominal** ☐ Ascites ☐ Appendix ☐ Colon ☐ Esophagus ☐ Gallbladder ☐ Liver ☐ Pancreas ☐ Rectum ☐ Small Intestine ☐ Stomach **Central Nervous System** ☐ Brain ☐ Cerebrospinal Fluid ☐ Epidural Space ☐ Lepomeninges **Lymph Nodes** ☐ Axillary ☐ Cervical ☐ Epitrochlear ☐ Femoral ☐ Hilar ☐ Iliac ☐ Iliac-common ☐ Iliac-external ☐ Inguinal ☐ Mediastinal ☐ Mesenteric ☐ Occipital ☐ Paraaortic ☐ Parotid ☐ Popliteal ☐ Retroperitoneal ☐ Splenic ☐ Supraclavicular ☐ Submandibular ☐ No Known Nodal Involvement	Using the list of sites in the nodal and extranodal questions above, provide the anatomic site of the maximum tumor bulk. 3639616
Pathologic Diagnosis and Surgical Resection			
*48	Date of Initial Pathologic Diagnosis	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date the patient was initially diagnosed with the malignancy submitted for BLGSP. This may or may not be the date of the surgical resection that yielded the tumor sample submitted for BLGSP. 2896956 (month), 2896958 (day), 2896960 (year) *Note: The day of Initial Pathologic Diagnosis is not required.*
49	Initial Pathologic Diagnosis Acquisition Method	☐ Incisional Biopsy ☐ Excisional Biopsy ☐ Core Biopsy ☐ Blood Draw ☐ Bone Marrow Aspirate ☐ Other (please specify) ☐ Unknown	Provide the method of the initial pathologic diagnosis. This is the method used on the date provided above. 2757941
50	Other Method of Initial Pathologic Diagnosis Only complete if "other" is selected above.	_____	If the method of initial pathologic diagnosis is not included in the list above, provide the method used. 2757948
51	Date of Tumor Sample Procurement	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date of the surgical resection that yielded the tumor sample submitted for BLGSP. 3008197 (month), 3008195 (day), 3008199 (year)
Lymph Node Status			
52	Were Lymph Nodes Examined at the Time of Primary Resection?	☐ Yes ☐ No ☐ Unknown	Indicate whether any lymph nodes were examined at the time of the primary resection. 2200396

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53	Number of Lymph Nodes Examined Only complete if "yes" is selected above.	_____	Provide the number of lymph nodes examined, if one or more lymph nodes were removed. 3
54	Number of Lymph Nodes Positive by H&E light microscopy Only complete if "yes" is selected above.	_____	Provide the number of lymph nodes positive through hematoxylin and eosin (H&E) staining and light microscopy. 3086388
55	Number of Lymph Nodes Positive by IHC Keratin Staining only Only complete if "yes" is selected above.	_____	Provide the number of lymph nodes positive through keratin immunohistochemistry (IHC) staining. 3086383
56	Pathologic Positive Lymph Node Location(s) *(Check all that apply)* Only complete if "yes" is selected above.	☐ Pelvic (external iliac, internal iliac, obturator) ☐ Common iliac ☐ Paraaortic ☐ Supraclavicular ☐ Unknown ☐ Other, specify	Using the patient's pathology/laboratory report, provide the location(s) of any positive lymph nodes. 3151519
57	Other Positive Lymph Node Only complete if "other" is selected above.	_____	If the location of positive lymph nodes was not included in the list provide, please provide the location of positive lymph nodes. 3151522
Staging and Histology of Bone Marrow			
*58	Tumor Stage (Follow Ann Arbor Criteria)	☐ Stage I ☐ Stage II ☐ Stage III ☐ Stage IV	Using the patient's pathology/laboratory report in conjunction with the patient's medical record, select the clinical or pathological stage as defined by the American Joint Committee on Cancer (AJCC). 3203222
*59	Are "B" Symptoms Present?	☐ Yes ☐ No	Using the patient's medical record, indicate whether there is documentation of "B" symptoms. *Note: "B" symptoms are defined as unexplained fevers, drenching night sweats, or unexplained weight loss of more than 10% of usual body weight in the six months prior to lymphoma diagnosis.* 2902402
*60	Lymphomatous Involvement of Extranodal "E" Site?	☐ Yes ☐ No	Using the patient's medical record, indicate whether there is documentation of extranodal site involvement. *Note: If the answer is "Yes", the anatomic site(s) of extranodal involvement should be included inextranodal site question above.* 3364582
61	Presence of Malignant Cells in Bone Marrow by Histology	☐ Yes ☐ No ☐ Unknown	Indicate if malignant cells are histologically confirmed in the patient's bone marrow. 2180550
62	Histology of Bone Marrow Samples	☐ Concordant Histology ☐ Discordant Histology ☐ Unknown	If malignant cells are present in the bone marrow at the time of initial staging workup, determine if the histologic diagnosis of the bone marrow is concordant with the diagnosis of BL. 3233401
Tests Performed			
LDH Level (at the time of staging)			
*63	LDH Level	_____(IU)	Record the result of the LDH lab test performed during the staging workup. 2798766
*64	LDH Level Upper Limit for Normal at Facility	_____(IU)	Record the upper limit of the normal range of the LDH lab test performed at the reporting facility. 2953115
Genetic Testing			
65	Tests Performed for Immunophenotyping	(+) (-) Indeterminate Ki-67 > 90% ☐ ☐ ☐ CD10 > 30% ☐ ☐ ☐ BCL2 ☐ ☐ ☐	Indicate all tests performed for immunophenotypic analysis in order to classify clonal subgroups. 3234614 (test performed), 3234626 (Result)

#	Data Element	Entry Alternatives	Working Instructions
		CD20 ☐ ☐ ☐ BCL6 > 30% ☐ ☐ ☐ CD3 ☐ ☐ ☐ Other ☐ ☐ ☐	
66	Other Tests Performed for Immunophenotyping (please specify) Only complete if "other" is selected in previous question.	_____	Indicate all tests performed for immunophenotypic analysis in order to classify clonal subgroups. 2516429
67	B-cell Immunophenotype Methodology	☐ Immunohistochemistry ☐ Flow Cytometry, not otherwise specified ☐ Immunofluorescence ☐ Other	If B-cell genotype was performed, indicate the testing method used. 64540
Genetic Abnormalities			
68	Genetic Abnormalities	N T G A L O C-MYC ☐ ☐ ☐ ☐ ☐ ☐ BCL2 ☐ ☐ ☐ ☐ ☐ ☐ BCL6 ☐ ☐ ☐ ☐ ☐ ☐	Indicate all genetic abnormalities for which the patient was tested. 3234675, 3234680 N = Normal T = Translocation G = Gain L = Loss A = Amplification O = Other
69	Other Genetic Abnormalities *(please specify)*	N T G A L O _____ ☐ ☐ ☐ ☐ ☐ ☐ _____ ☐ ☐ ☐ ☐ ☐ ☐ _____ ☐ ☐ ☐ ☐ ☐ ☐ _____ ☐ ☐ ☐ ☐ ☐ ☐	Specify any other genetic abnormalities not in the provided list for which the patient was tested. 3234685, 3234680
70	Other Results of Testing for Genetic Abnormality	Other Results C-MYC BCL2 BCL6 Other	Specify any other results of testing for genetic abnormalities not in the provided list . 4459354
71	Methodology Used in Testing for Genetic Abnormality Only complete if patient had a genetic abnormality.	1 2 3 4 C-MYC ☐ ☐ ☐ ☐ BCL2 ☐ ☐ ☐ ☐ BCL6 ☐ ☐ ☐ ☐ Other ☐ ☐ ☐ ☐	If the patient was tested for a specific genetic abnormality, indicate the testing method used to perform each analysis. 3234684 Methodology Code: 1 = PCR 2 = Southern Blot 3 = FISH 4 = Cytogenetic
72	Methodology Used to Determine EBV Status of Malignant Cells	☐ EBER in situ Hybridization ☐ LMP Immunohistochemistry ☐ EBV PCR ☐ Unknown	If the patient's EBV status was positive, provide the testing method used to determine the EBV status of the malignant cells. 3233656
73	EBV Status of Malignant Cells	☐ Positive ☐ Negative ☐ Unknown	Provide the result of the lab test to detect the presence of Epstein/Barr Virus antibody in the patient. 2003961
74	If EBV status is positive, provide the percent positive. (does not include background positives) Only complete if "positive" is selected above.	_____**(%)**	If the patient's EBV status was positive, provide the percentage of EBV positive malignant cells. Do not include the number of background positives. 3233649

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.*

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i*	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 initial treatment. 3121376 If the patient did not have a new tumor event or if this is unknown, the remaining questions can be skipped.
ii†	Date of New Tumor Event	____ ____ ____ ____ ____ ____ ____ ____ *Month* *Day* *Year*	If the patient had a new tumor event, provide the date of diagnosis for this new tumor event. 3104044 (Month), 3104042 (Day), 3104046 (Year)
iii	Type of New Tumor Event	☐ Locoregional Recurrence ☐ Distant Metastasis ☐ New Primary Tumor	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. 3119721
iv	Anatomic Site of New Tumor Event	☐ Bone ☐ Retroperitoneum ☐ Lung ☐ Lymph Node(s) ☐ Liver ☐ Other, specify	Indicate the site of this new tumor event. 3108271
v	Other Site of New Tumor Event	_____	If the site of the new tumor event is not included in the provided list, describe the site of this new tumor event. 3128033
vi	Diagnostic Evidence of Recurrence / Relapse (check all that apply)	☐ Biopsy w/Histologic Confirmation ☐ Convincing Imaging (i.e. CT, PET, MRI) ☐ Positive Biomarker(s)	Indicate the procedure or testing method used to diagnose tumor recurrence or relapse. 2786205
vii	Additional Surgery for New Tumor Event	☐ Yes ☐ Unknown ☐ No	Using the patient's medical records, indicate whether the patient had surgery for the new metastatic tumor event in question. 3427611
viii	Additional Treatment of New Tumor Event Radiation Therapy	☐ Yes ☐ Unknown ☐ No	Indicate whether the patient received radiation treatment for this new tumor event. 3427615
ix	Additional Treatment of New Tumor Event Pharmaceutical Therapy	☐ Yes ☐ Unknown ☐ No	Indicate whether the patient received pharmaceutical treatment for this new tumor event. 3427616
Patient Status			
*75	Is This Patient Lost to Follow-up?	☐ Yes ☐ No	Indicate whether the patient is lost to follow-up as defined by the ACoS Commission on Cancer. This only includes cases where updated information has not been collected within the last 15 months. If the patient is lost to follow-up, the remaining questions may be left unanswered. 61333 *If the patient is lost to follow-up or deceased at the time of enrollment, follow-up forms are not required.*

Principal Investigator (*Printed Name*)

Principal Investigator (*Signature*) Date

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