Treatment Supplemental Form

HIV+ Tumor Molecular Characterization Project (HTMCP)

Instructions: *The HTMCP treatment forms act as supplemental forms to the Follow-up form and are due at the time the Follow-up form is submitted to the BCR. However, if the patient has completed treatment or if the patient is deceased, these forms can be submitted to the BCR at the time the Enrollment form is submitted.*

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

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

Completed By: _____Completed Date: _____

#	Data Element	Entry Alternatives	Working Instructions
1*	Was this treatment(s) used to treat the primary tumor or a tumor coming from the initial primary tumor (e.g. recurrence, relapse, and metastasis)?	☐ Yes ☐ No	This form should only be completed for treatment(s) of the primary tumor or a tumor coming from the initial primary tumor (e.g. recurrence, relapse, and metastasis). If the answer to this question is "no", or if the treatment was given to treat an unrelated primary, no additional information is required.
2†	Reason for Treatment	☐ Initial Diagnosis ☐ Progression ☐ Recurrence/Relapse	Indicate the reason the specific treatment was administered. 2793511
3†	Treatment Type	☐ Chemotherapy ☐ Radiation ☐ Stem Cell Transplant ☐ Surgery ☐ No Treatment ☐ Other Treatment	Indicate the type of treatment administered. 5102381
4†	Other Treatment Type	_____	If the treatment type was not included in the provided list, specify the other treatment type. 5544691
5†	Other Treatment Start Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date that therapy was started. 3103072 (month), 3103070 (day), 3103074 (year)
6†	Other Treatment End Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date that therapy was completed/ ended. 3103080 (month), 3103078 (day), 3103082 (year)
Chemotherapy ***(please answer following questions only if Chemotherapy was selected above.)***			
7†	Chemotherapy Start Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date the chemotherapy regimen started. 2897050 (month), 2897052 (day), 2897054 (year)
8†	Did chemotherapy end during this reporting period?	☐ Yes ☐ No	Indicate whether chemotherapy administration ended during this reporting period. 2188260
9†	Chemotherapy End Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date the chemotherapy regimen ended. 2897056 (month), 2897058 (day), 2897060 (year)
10†	Pharmaceutical Regimen	**Cervical Regimen(s)** ☐ Paclitaxel + Cisplatin **DLBCL Regimen(s)** ☐ BACOP ☐ C-MOPP ☐ CAP-BOP ☐ CHOP + Bleomycin ☐ CHOP + Etoposide ☐ CHOP-14 ☐ CHOP-14 + Rituximab ☐ CHOP-21 ☐ CHOP-21 + Rituximab ☐ CNOP ☐ CODOX + Rituximab ☐ CVP ☐ DA-EPOCH ☐ DA-EPOCH + Rituxumab	Provide the term or abbreviation that represents the name of the pharmaceutical regimen containing two or more agents which were given together or separately to treat the patient. 5544720

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		☐ F-MACHOP ☐ High Dose Methotrexate w/Leucovorin ☐ HyperCVAD-Mtx/AraC + Rituximab ☐ ICE ☐ ICE + Rituxumab ☐ LNH-84 ☐ LNH-87 ☐ M-BACOP ☐ MACOP-B ☐ ProMace-CytaBOM ☐ ProMace-MOPP ☐ VACOP-B ☐ Vanderbilt regimen + Rituximab **Lung Regimen(s)** ☐ Carboplatin + Paclitaxel ☐ CAV (Cyclophosphamide, Adriamycin and Vincristin) ☐ CE (Cisplatin and Etoposide) **Other** ☐ Single Agent Therapy (please specify) ☐ Other Pharmaceutical Regimen (please specify) ☐ Unknown	
11†	If Other Pharmaceutical Regimen, specify	_____	If the pharmaceutical regimen was not included in the provided list, specify the name or abbreviation of a pharmaceutical regimen containing two or more agents which are given together or separately to treat the patient. 5544692
12†	Single-Agent Therapy	**Lung Agents** ☐ Adriamycin ☐ Carboplatin ☐ Cisplatin ☐ Cyclophosphamide ☐ Erlotinib ☐ Etoposide ☐ Paclitaxel ☐ Vincristine **Cervical Agents** ☐ Cisplatin ☐ Pacitaxel **Other** ☐ Other Single Agent Therapy (please specify) ☐ Unknown	Provide the name for the single agent used to treat the patient. 5544729
13†	If Other Single-Agent Therapy, specify	_____	If the name for the single-agent used to treat the patient was not included in the provided list, specify the name. 5544693
14†	Number of Cycles	_____	Provide the total number of cycles of the specific agent or regimen administered to the patient. 62590
Radiation Therapy ***(please answer following questions only if Radiation was selected in the treatment type question above)***			
15†	Radiation Therapy Start Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date the radiation therapy started. 2897100 (month), 2897102 (day), 2897104 (year)
16†	Did radiation therapy end during this reporting period?	☐ Yes ☐ No	Indicate whether radiation therapy ended during this reporting period. 4618471
17†	Radiation Therapy End Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date the radiation therapy ended. 2897106 (month), 2897108 (day), 2897110 (year)
18†	Total Dose of Radiation Therapy	_____ (Gy)	Provide the total dose volume of radiation therapy given to a patient, in Gray. 36

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#	Data Element	Entry Alternatives	Working Instructions
19†	Radiation Field	☐ Abdomen, total ☐ Arm ☐ Body, Total ☐ Bone, Non-spine ☐ Brain, Focal ☐ Brain, Whole ☐ Breast ☐ Chest Wall ☐ Eye ☐ Gastrointestinal, Colon ☐ Gastrointestinal, Gallbladder ☐ Gastrointestinal, Intestine ☐ Gastrointestinal, Liver ☐ Gastrointestinal, NOS ☐ Gastrointestinal, Pancreas ☐ Gastrointestinal, Stomach ☐ Genitourinary, Bladder ☐ Genitourinary, Kidney ☐ Genitourinary, NOS ☐ Head, Face, or Neck ☐ Leg ☐ Lung ☐ Lymph Nodes, NOS ☐ Lymph Node, Axillary ☐ Lymph Nodes, Cervical ☐ Lymph Nodes, Epitrochlear ☐ Lymph Nodes, Femoral ☐ Lymph Node, Hilar ☐ Lymph Node, Iliac-common ☐ Lymph Node, Iliac-external ☐ Lymph Node, Inguinal ☐ Lymph Node, Mediastinal ☐ Lymph Node, Mesenteric ☐ Lymph Node, Occipital ☐ Lymph Node, Paraaortic ☐ Lymph Node, Parotid ☐ Lymph Node, Popliteal ☐ Lymph Node, Retroperitoneal ☐ Lymph Node, Splenic ☐ Lymph Node, Submandibular ☐ Lymph Node, Supraclavicular ☐ Mantle ☐ Mediastinum ☐ Parametrium ☐ Pelvis ☐ Shoulder ☐ Skin, lower extremity, local ☐ Skin, total ☐ Skin, trunk, local ☐ Skin, upper extremity, local ☐ Spine ☐ Supraclavicular ☐ Thorax ☐ Trunk ☐ Other ☐ Unknown	Indicate the anatomic site(s) or field(s) that was targeted for radiation therapy. 2416537
20†	Other Region Targeted	_____	If the anatomic site(s) or field(s) was not included in the provided list, specify the site or field. 62999
Stem Cell Transplantation ***(please answer following questions only if Stem Cell Transplantation was selected in the treatment type question above)***			
21†	Type of Stem Cell Transplantation	☐ Autologous ☐ Syngeneic/Allogeneic related donor ☐ Allogeneic, unrelated donor	Indicate the hematopoietic stem cell source type. 2957417
22†	Date of Stem Cell Transplantation	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date of the hematopoietic stem cell transplant. 3366911 (month), 3366912 (day), 3366913 (year)
Surgery ***(please answer following questions only if Surgery was selected in the treatment type question above)***			
23†	Date of cancer debulking surgery	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date of the debulking surgery to remove as much of the tumor as possible. 4631583 (month), 4631581(day), 4631584 (year)
24†	Measure of Best Response of Treatment	☐ Complete Response ☐ Partial Response ☐ Stable Disease ☐ Progressive Disease ☐ Not Applicable (Therapy Ongoing) ☐ Unknown	Indicate the patient's outcome (response) at the end of this treatment regimen. 2857291

_____ _____ ___ ___/ ___ ___/ ___ ___ ___ ___

Principal Investigator or Designee Signature | Print Name | Date