Treatment Supplemental Form

Instructions: *The BLGSP 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 *(Interviewer Name on OpenClinica)*: _____Completed Date: _____

#	Data Element	Entry Alternatives	Working Instructions
1*	Indication of Regimen	☐ Initial ☐ Adjuvant ☐ Progression after initial ☐ Recurrence ☐ Palliative ☐ Unknown	Text term to identify the reason for the administration of a treatment regimen. 5102381
2*	Lymphoma Treatment Type	☐ Chemotherapy ☐ Radiation ☐ Stem Cell Transplant ☐ Surgery ☐ No Treatment ☐ Other Treatment	Text term that describes the kind of treatment that was given for the primary lymphoma. 5544691
3	Other Lymphoma Treatment Type	_____	Indicate the other treatment type for the lymphoma. 2861111
4†	Other Treatment Start Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date that therapy was started. 3103072 (month), 3103070 (day), 3103074 (year)
5†	Other Treatment End Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Provide the date that therapy was completed/ ended. 3103080 (month), 3103078 (day), 31030782 (year)
Chemotherapy ***(please answer following questions only if Chemotherapy was selected above.)***			
6†	Chemotherapy Start Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Date chemotherapy regimen started. 2897050 (month), 2897052 (day), 2897054 (year)
7	Did chemotherapy end during this reporting period?	☐ Yes ☐ No	Indicate whether chemotherapy administration ended during this reporting period. 2188260
8†	Chemotherapy End Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Date chemotherapy regimen ended. 2897056 (month), 2897058 (day), 2897060 (year)
9†	Pharmaceutical Regimen	☐ 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 ☐ F-MACHOP ☐ High Dose Methotrexate w/Leucovorin ☐ HyperCVAD-Mtx/AraC + Rituximab ☐ ICE ☐ ICE + Rituxumab ☐ LNH-84 ☐ LNH-87 ☐ M-BACOP ☐ MACOP-B	Text term or code to represent the name of a pharmaceutical regimen containing two or more agents which are given together or separately to treat a patient with malignant lymphoma. 3366758

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#	Data Element	Entry Alternatives	Working Instructions
		☐ ProMace-CytaBOM ☐ ProMace-MOPP ☐ VACOP-B ☐ Vanderbilt regimen + Rituximab ☐ Single Agent Therapy (please specify) ☐ Other Pharmaceutical Regimen (please specify) ☐ Unknown	
10	If Other Pharmaceutical Regimen, specify	_____	Text term or abbreviation to represent another name of a pharmaceutical regimen containing two or more agents which are given together or separately to treat a patient with malignant lymphoma that was not already mentioned or specified. 3366930
11	If Single-Agent Therapy, specify	_____	Text name for agent used without other agents in a treatment regimen or study. 3590022
12	Number of Cycles	_____	The total number of cycles administered to the patient of a protocol specified drug or therapy agent as of the current report. 62590
Radiation Therapy ***(please answer following questions only if Radiation was selected in the treatment type question above)***			
13†	Radiation Therapy Start Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Date radiation therapy started. 2897100 (month), 2897102 (day), 2897104 (year)
14	Did radiation therapy end during this reporting period?	☐ Yes ☐ No	Indicate whether radiation therapy ended during this reporting period. 4618471
15†	Radiation Therapy End Date	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Date radiation therapy ended. 2897106 (month), 2897108 (day), 2897110 (year)
16	Total Dose of Radiation Therapy	_____ (Gy)	A numeric value for the total dose volume of radiation therapy given to a patient, in Gray. 36
17†	Radiation Field, extranodal	☐ 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 node, distant (specify site) ☐ Lymph node, locoregional (specify site) ☐ Lymph Nodes ☐ Mantle ☐ Mediastinum ☐ Parametrium ☐ Pelvis ☐ Shoulder ☐ Skin, lower extremity, local ☐ Skin, total ☐ Skin, trunk, local ☐ Skin, upper extremity, local ☐ Spine ☐ Supraclavicular ☐ Thorax ☐ Trunk ☐ Other ☐ Unknown	Text term to identify anatomically-specified areas or fields that are targeted for radiation therapy. 2416537
18	Nodal Regions Targeted	☐ Axillary ☐ Cervical ☐ Epitrochlear ☐ Femoral ☐ Hilar ☐ Iliac-common ☐ Iliac-external ☐ Inguinal ☐ Mediastinal ☐ Mesenteric ☐ Occipital ☐ Paraaortic ☐ Parotid ☐ Popliteal ☐ Retroperitoneal ☐ Splenic ☐ Submandibular ☐ Supraclavicular	Identify lymph node sites targeted for radiation therapy. 3762198
19	Other Region Targeted	_____	Specify other field of radiation 62999

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#	Data Element	Entry Alternatives	Working Instructions
Stem Cell Transplantation ***(please answer following questions only if Stem Cell Transplantation was selected in the treatment type question above)***			
20	Type of Stem Cell Transplantation	☐ Autologous ☐ Syngeneic/Allogeneic related donor ☐ Allogeneic, unrelated donor	Indicate the hematopoietic stem cell source type. 2957417
21†	Date of Stem Cell Transplantation	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Indicate 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)***			
22†	Date of cancer debulking surgery	____ ____ / ____ ____ / ____ ____ ____ ____ (month) (day) (year)	Indicate the date of the the procedure of surgically removing as much of the tumor as possible. 4631583 (month), 4631581(day), 4631584 (year)
23*	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