

Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial

Version No.: 07/01

MEDICAL RECORD ABSTRACT FORM TREATMENT INFORMATION - LUNG (TIL2/TLQ2)

1. Date Abstracted:

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4. Study Year T0-T13:

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5. Purpose of Abstract:

Initial abstract
 Re-abstract for QA

FOR OFFICE USE ONLY

Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)

6.

Data Entry of Non-Scannable Items:

Data Retrieval:

Form Received into SMS
Manual Review Completed

Completed None Required

Attempted None Required

Disposition:

Interim Complete (ICM) Final Complete (FCM) Final Incomplete (FIC)

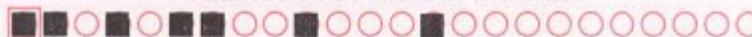
PART A: INITIAL TREATMENT INFORMATION

1. RADIATION TREATMENT FOR LUNG CANCER:

No
 Yes (COMPLETE TABLE BELOW)
 Unknown

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PART A CONTINUED . . .

2. SURGICAL TREATMENT FOR LUNG CANCER:

No

Yes (COMPLETE TABLE BELOW)

Unknown

PROCEDURE #	1	2	3	4																																																																																																																																				
TYPE OF SURGICAL PROCEDURE (SEE SURGICAL PROCEDURE CODES BELOW. IF OTHER, SPECIFY)	01 02 04 06 08 11 12 13 14 15 16 88	01 02 04 06 08 11 12 13 14 15 16 88	01 02 04 06 08 11 12 13 14 15 16 88	01 02 04 06 08 11 12 13 14 15 16 88																																																																																																																																				
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SURGICAL PROCEDURE CODES

01 = Exploratory thoracotomy without resection
 02 = Mediansternotomy
 04 = Lobectomy
 06 = Bilobectomy
 08 = Pneumonectomy

11 = Wedge resection
 12 = Segmental resection
 13 = Lymphadenectomy/Lymph node sampling
 14 = Chest wall resection
 15 = Thoracentesis

16 = Partial pleurectomy
 88 = Other (SPECIFY)

3. CHEMOTHERAPEUTIC TREATMENT FOR LUNG CANCER:

No

Yes (COMPLETE TABLE BELOW)

Unknown

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4. OTHER TYPE OF TREATMENT FOR LUNG CANCER:

- No
 Yes (COMPLETE TABLE BELOW)
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5. ANY LOCAL OR REGIONAL RESIDUAL DISEASE LEFT AFTER SURGERY:

- No
 Not applicable
 Yes - Microscopic
 Unknown
 Yes - Gross Tumor

PART B: PHYSICIAN/HOSPITAL LOCATION INFORMATION

6. PHYSICIAN FOR TREATMENT:

a. Name: _____

Address: _____

City State ZIP Code

Telephone: (_____) _____ Medical Record/Chart # _____

b. Name: _____

Address: _____

City State ZIP Code

Telephone: (_____) _____ Medical Record/Chart # _____

7. HOSPITAL OR CLINIC FOR TREATMENT:

a. Name: _____

Address: _____

City State ZIP Code

Telephone: (_____) _____ Medical Record/Chart # _____

b. Name: _____

Address: _____

City State ZIP Code

Telephone: (_____) _____ Medical Record/Chart # _____

