Participant ID Number

Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

MEDICAL RECORD ABSTRACT FORM TREATMENT INFORMATION – OVARY (TIO2/TOQ2)

1. **Date Abstracted:** _____
   Month Day Year
2. **Abstractor ID#:** ___ ___ ___ ___
3. **CTR ID:** ___ ___ ___ ___
4. **Study Year T0-T13:** ___ ___
5. **Purpose of Abstract:**
   ○ Initial abstract
   ○ Re-abstract for QA

FOR OFFICE USE ONLY

6. **Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)**
   ○ Form Receipted into SMS
   ○ Manual Review Completed

   Data Entry of Non-Scannable Items:
   ○ Completed
   ○ None Required

   Data Retrieval:
   ○ Attempted
   ○ None Required

   Disposition:
   ○ Interim Complete (ICM)
   ○ Final Complete (FCM)
   ○ Final Incomplete (FIC)

PART A: INITIAL TREATMENT INFORMATION

1. SURGICAL TREATMENT FOR OVARIAN CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

PROCEDURE #	1	2	3	4
TYPE OF SURGICAL PROCEDURE **(SEE SURGICAL PROCEDURE CODES BELOW. IF OTHER, SPECIFY)**	_____ **SPECIFY**	_____ **SPECIFY**	_____ **SPECIFY**	_____ **SPECIFY**
DATE OF SURGERY (MO.-DAY-YEAR)				

SURGICAL PROCEDURE CODES

05 = Bilateral salpingooophorectomy
06 = Unilateral salpingooophorectomy
08 = Pelvic exenteration, partial or total
09 = Abdominal/vaginal hysterectomy
10 = Adhesiolysis
11 = Bowel resection
12 = Lymphadenectomy/Lymph node sampling
13 = Omentectomy, complete/NOS
14 = Omentectomy, partial
15 = Resection (SPECIFY)
16 = Tumor debulking (Cytoreductive surgery)
88 = Other (SPECIFY)

2. RADIATION TREATMENT FOR OVARIAN CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

TREATMENT #	1	2
DATE RADIATION TREATMENT BEGAN (MO.-DAY-YEAR)		

3. CHEMOTHERAPEUTIC TREATMENT FOR OVARIAN CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

TREATMENT #	1	2
DATE CHEMOTHERAPEUTIC TREATMENT BEGAN (MO.-DAY-YEAR)		

4. OTHER TYPE OF TREATMENT FOR OVARIAN CANCER:

○ No

○ Yes (COMPLETE TABLE BELOW)

○ Unknown

TREATMENT #	1	2
DATE OTHER TREATMENT BEGAN (MO.-DAY-YEAR)		

5. ANY LOCAL OR REGIONAL RESIDUAL DISEASE LEFT AFTER SURGERY:

○ No

○ Yes – Macroscopic <2cm

○ Yes – Macroscopic ≥2cm

○ Yes – Microscopic

○ Not applicable

○ Unknown

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 #** _____

8. COMMENTS:

○ No

○ Yes (SPECIFY)

Item #	Comments

○ (CONTINUED)