National Lung Screening Trial / Lung Screening Study (NLST/LSS)

MEDICAL RECORD ABSTRACT TREATMENT INFORMATION FORM (TI)

Administrative Section	
Date Abstracted: |__|__| / |__|__| / |__|__|__|__| Abstractor ID: |__|__|__|__| Screening Center ID: |__|__| Study Year: T|__| Purpose of Abstract: ☐ Initial Abstract ☐ Re-abstract for QA Multiple DE #_____	Initials Complete: _____ Initials QC: _____ Participant ID Label

PART A: INITIAL TREATMENT FOR PRIMARY INVASIVE LUNG CANCER

1. Radiation Treatment For Primary Invasive Lung Cancer:
☐ No   (GO TO A.2)
☐ Yes
☐ Unknown   (GO TO A.2)

1a. Sequence of Radiation Treatment:
(CHECK ALL THAT APPLY)
☐ Pre-operative
☐ Post-operative
☐ Definitive
☐ Unknown

1b. Details of Radiotherapy Treatment:

Radiotherapy Site	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
Primary Chest Tumor and/or Regional Nodes	|__|__| / |__|__| / |__|__|__|__|	|__|__| / |__|__| / |__|__|__|__|
Prophylactic Brain	|__|__| / |__|__| / |__|__|__|__|	|__|__| / |__|__| / |__|__|__|__|
Other (Specify) _____	|__|__| / |__|__| / |__|__|__|__|	|__|__| / |__|__| / |__|__|__|__|
Unknown	|__|__| / |__|__| / |__|__|__|__|	|__|__| / |__|__| / |__|__|__|__|

2. Surgical Treatment for Primary Invasive Lung Cancer:
☐ No (GO TO A.4)
☐ Yes **(IF YES, COMPLETE CHART BELOW USING SURGICAL PROCEDURE CODES LISTED)**
☐ Unknown (GO TO A.4)

Surgical Procedure Code	Date of Procedure (mm-dd-yyyy)
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|

SURGICAL PROCEDURE CODES

01 – Exploratory thoracotomy without resection
02 = Median sternotomy
03 = Lobectomy
04 = Bilobectomy
05 = Pneumonectomy
06 = Wedge resection
07 = Segmental resection

08 = Lymphadenectomy/lymph node sampling
09 = Chest wall resection
10 = Thoracentesis
11 = Partial pleurectomy
12 = Multiple wedge resections
13 = Multiple segmental resections
88 = Other (SPECIFY)
99 = Unknown

3. Any Local or Regional Residual Disease After Surgery: ....
☐ No
(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)
☐ Yes – Microscopic
☐ Yes – Gross Tumor
CTR ID # |___|___|___|___|
☐ Unknown

4. Systemic Chemotherapy for Primary Invasive Lung Cancer:
☐ No (GO TO A.5)
☐ Yes **(IF YES, COMPLETE DATE CHEMOTHERAPY BEGAN)**
☐ Unknown (GO TO A.5)

Date Course of Chemotherapy Began:

|___|___| - |___|___| - |__|__|__|__|
  MO   DAY   YEAR

5. Other Type of Treatment for Primary Invasive Lung Cancer:

☐ No   (GO TO B.6)

☐ Yes   **(IF YES, COMPLETE TABLE BELOW SPECIFYING TYPE OF TREATMENT AND START DATE)**

☐ Unknown   (GO TO B.6)

Type of Treatment 01 Immune Therapy 02 Radiofrequency Ablation 03 Thermal Ablation 04 Chemical Ablation 05 Other (specify) 99 Unknown treatment	Treatment Start Date (mm-dd-yyyy)
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|
|__|__| _____	|__|__|-|__|__|-|__|__|__|__|

PART B: COMMENTS

6. Comments:

☐ No

☐ Yes **(IF YES, PLEASE SPECIFY)**

ITEM	COMMENTS

PART C: HEALTH CARE PROVIDER/HOSPITAL LOCATION INFORMATION

7. HEALTH CARE PROVIDER FOR TREATMENT:

a. NAME: MR./MRS./MISS/MS./DR.   FIRST   MIDDLE   LAST   (JR., SR., etc.)

STREET ADDRESS 1   STREET ADDRESS 2   SUITE OR OFFICE NO

CITY   STATE   ZIP

TELEPHONE 1   TELEPHONE 2   FAX NUMBER:
( )   ( )   ( )

MEDICAL RECORD / CHART NUMBER

b. NAME: MR./MRS./MISS/MS./DR.   FIRST   MIDDLE   LAST   (JR., SR., etc.)

STREET ADDRESS 1   STREET ADDRESS 2   SUITE OR OFFICE NO

CITY   STATE   ZIP

TELEPHONE 1   TELEPHONE 2   FAX NUMBER:
( )   ( )   ( )

MEDICAL RECORD / CHART NUMBER

8. HOSPITAL OR CLINIC FOR TREATMENT:

a. NAME OF HOSPITAL OR CLINIC

STREET ADDRESS 1   STREET ADDRESS 2   SUITE OR OFFICE NO

CITY   STATE   ZIP

TELEPHONE 1   TELEPHONE 2   FAX NUMBER:
( )   ( )   ( )

MEDICAL RECORD / CHART NUMBER

b. NAME OF HOSPITAL OR CLINIC

STREET ADDRESS 1   STREET ADDRESS 2   SUITE OR OFFICE NO

CITY   STATE   ZIP

TELEPHONE 1   TELEPHONE 2   FAX NUMBER:
( )   ( )   ( )

MEDICAL RECORD / CHART NUMBER