MEDICAL RECORD ABSTRACT
DIAGNOSTIC EVALUATION FORM (DE)

Administrative Section

☐ Please mark box if another DE form has been submitted for this participant.

Date Abstracted: |__|__| / |__|__| / |__|__|__|__|

Abstractor ID: |___|___|___|___|

Screening Center ID: |___|___|

Study Year: T|___|

☐ Please mark box if T_3 completion is due to T_2 positive screen.

Date of Screening Exam or CDF Completion Date:
|__|__| / |__|__| / |__|__|__|__|

Purpose of Abstract:
- ☐ Initial Abstract
- ☐ Re-abstract for QA

Multiple DE #_____

Initials Complete: _____

Initials QC: _____

Participant ID Label

PART A: DIAGNOSTIC EVALUATION AND STAGING

1. Did participant undergo diagnostic procedures?
   - ☐ Yes
   - ☐ No, Physician Report **(GO TO A.5)**
   - ☐ No, Participant Self-Report **(GO TO A.5)**

2. Reason for initial visit for diagnostic evaluation: (Mark all that apply)
   - ☐ Symptomatic
   - ☐ Follow-up of positive NLST screen
   - ☐ Other (SPECIFY)_____

3. Diagnostic Evaluations **(DO NOT RECORD RESULTS OF SCREENING SPIRAL CT SCAN OR CHEST X-RAY EXAM)**

PROCEDURE #	DATE OF PROCEDURE (MO/DAY/YR)	TYPE OF PROCEDURE **(USE PROCEDURE CODES ON THE NEXT PAGE)**
1	|__|__|-|__|__|-|__|__|__|__|	|__|__|
2	|__|__|-|__|__|-|__|__|__|__|	|__|__|
3	|__|__|-|__|__|-|__|__|__|__|	|__|__|
4	|__|__|-|__|__|-|__|__|__|__|	|__|__|
5	|__|__|-|__|__|-|__|__|__|__|	|__|__|
6	|__|__|-|__|__|-|__|__|__|__|	|__|__|
7	|__|__|-|__|__|-|__|__|__|__|	|__|__|
8	|__|__|-|__|__|-|__|__|__|__|	|__|__|
9	|__|__|-|__|__|-|__|__|__|__|	|__|__|
10	|__|__|-|__|__|-|__|__|__|__|	|__|__|
11	|__|__|-|__|__|-|__|__|__|__|	|__|__|
12	|__|__|-|__|__|-|__|__|__|__|	|__|__|
13	|__|__|-|__|__|-|__|__|__|__|	|__|__|
14	|__|__|-|__|__|-|__|__|__|__|	|__|__|
15	|__|__|-|__|__|-|__|__|__|__|	|__|__|
16	|__|__|-|__|__|-|__|__|__|__|	|__|__|
17	|__|__|-|__|__|-|__|__|__|__|	|__|__|
18	|__|__|-|__|__|-|__|__|__|__|	|__|__|

PROCEDURE CODES

01 = Biopsy – Endobronchial	29 = Lymphadenectomy/lymph node sampling
04 = Biopsy – Lymph node, scalene (supraclavicular) nodes	30 = Mediastinoscopy/Mediastinotomy
03 = Biopsy – Lymph node, other **(Specify)**	62 = MRI – Abdomen (or liver)
09 = Biopsy – Open surgical	31 = MRI – Bone
52 = Biopsy – Percutaneous adrenal	32 = MRI – Brain
02 = Biopsy – Percutaneous liver	33 = MRI – Chest
53 = Biopsy – Percutaneous transthoracic yielding histology	35 = MRI – Other **(Specify)**
50 = Biopsy – Thoracoscopic	39 = Pulmonary function tests/spirometry
10 = Biopsy – Transbronchial	11 = Radiograph – Bone
08 = Biopsy – Other **(Specify)**	13 = Radiograph – Chest
54 = Bronchoscopy without biopsy or cytology	15 = Radiograph – Comparison with historical images
14 = Clinical evaluation	37 = Radiograph – Other **(Specify)**
55 = CT – Abdomen (or liver)	40 = Radionuclide scan – Bone
17 = CT – Abdomen and pelvis	41 = Radionuclide scan – Brain
18 = CT – Brain	63 = Radionuclide scan – FDG-PET scan
56 = CT – Chest, plus contrast-enhanced nodule densitometry	68 = Radionuclide scan – Fusion PET/CT scan
57 = CT – Chest, diagnostic	64 = Radionuclide scan – Gallium
69 = CT – Chest, low dose spiral	42 = Radionuclide scan – Liver
23 = CT – Chest, limited thin section of nodule	65 = Radionuclide scan – Somatostatin receptor
70 = CT – Chest, limited thin section of entire lung	66 = Radionuclide scan – Ventilation/perfusion lung
71 = CT – Chest and abdomen	67 = Radionuclide scan - Other **(Specify)**
72 = CT – Chest, abdomen, and pelvis	43 = Resection
22 = CT – Other **(Specify)**	47 = Thoracentesis
58 = Cytology – Bronchoscopic	49 = Thoracoscopy
59 = Cytology – Percutaneous transthoracic	46 = Thoracotomy
25 = Cytology – Sputum	48 = Ultrasound **(Specify)**
60 = Cytology – Other **(Specify)**	36 = Other **(Specify)**
61 = Echocardiography	99 = Unknown
27 = Fluoroscopy	

COMPLICATION CODES

01 = Acute respiratory failure	17 = Hospitalization post procedure
02 = Allergic reaction	37 = Infection requiring antibiotics
03 = Anaphylaxis	31 = Injury to vital organ or vessel
05 = Blood loss requiring transfusion	21 = Myocardial Infarction
06 = Bronchopulmonary fistula	22 = Pain requiring referral to a pain specialist
29 = Bronchial stump leak requiring tube thoracostomy or other drainage for >4 days	23 = Pneumothorax requiring tube placement
	32 = Prolonged mechanical ventilation over 48 hours post-operatively
07 = Bronchospasm	25 = Respiratory arrest
08 = Cardiac arrest	26 = Rib fracture(s)
09 = Cardiac arrhythmia requiring medical intervention	33 = Thromboembolic complications requiring intervention
10 = Cerebral vascular accident (CVA)/stroke	34 = Vaso-vagal reaction
11 = Congestive heart failure (CHF)	27 = Vocal cord immobility/paralysis
12 = Death	28 = Wound dehiscence
30 = Empyema	36 = Wound infection
14 = Fever requiring antibiotics	35 = Other (**Specify**)
16 = Hemothorax requiring tube placement	99 = Unknown

4. Were there any medical complications as a result of diagnostic evaluation and staging?

☐ No **(Go to A.5)** ☐ Yes **(COMPLETE TABLE BELOW)** ☐ Unknown

DATE OF COMPLICATION MO DAY YEAR	MEDICAL COMPLICATIONS (USE COMPLICATION CODES ON PREVIOUS PAGE; LIST MORE THAN ONE IF NEEDED.)
	|__|__|
	|__|__|
	|__|__|
	|__|__|
	|__|__|

5. Result of Diagnostic Evaluation for Primary Invasive Lung Cancer:

☐ No malignancy, confirmed by histology or cytology
☐ No malignancy, determined by clinical evaluation only-no pathologic proof
☐ Primary invasive lung malignancy confirmed histologically
☐ Primary invasive lung malignancy confirmed cytologically
☐ Primary invasive lung malignancy diagnosed by clinical examination only-no pathologic proof
☐ Malignancy other than primary invasive lung cancer, with or without lung metastasis, confirmed by histology or cytology
☐ Malignancy other than primary invasive lung cancer, with or without lung metastasis, diagnosed by clinical evaluation only – no pathologic proof
☐ Diffuse idiopathic pulmonary neuroendocrine hyperplasia
☐ Neoplasm of uncertain behavior
☐ Carcinoma in situ
☐ Squamous dysplasia
☐ Atypical adenomatous hyperplasia
☐ Further follow-up required **(Go to PART D)**
☐ No information available **(Go to PART D)**

PART B: DIAGNOSIS INFORMATION FOR ANY CONDITION OTHER THAN PRIMARY INVASIVE LUNG CANCER

6a. Non-Cancer Diagnosis ☐ Yes ☐ No

ICD-9-CM Classification:

|___|___|___| . |___|___| Nosologist/Abstractor ID #:

6b. Date of Diagnosis: |___|___|___|___|

|___|___| / |___|___|/ |___|___|___|___|

7a. Cancer Diagnosis, Site other than primary invasive lung ☐ Yes ☐ No

ICD-O-3 Cancer Classification: **(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)**

|_C_|___|___|___| - |___|___|___|___| - |___| - |___|

TOPOGRAPHY MORPHOLOGY BEHAVIOR GRADE

7b. |___|___| / |___|___|/ |___|___|___|___| |___|___|___|___|

Date of Diagnosis CTR ID #

7c. Is this Cancer Metastatic to Lung? ☐ Yes ☐ No

PART C: PRIMARY INVASIVE LUNG CANCER DIAGNOSIS INFORMATION

8. Date of Primary Invasive Lung Cancer Diagnosis (Mo/Day/Year):
|___|___| / |___|___|/ |___|___|___|___|

9. Photocopy of Report Confirming Primary Invasive Lung Cancer (**MARK ONE**):

- ☐ No Report/Clinical Examination **(COMPLETE C10)**
- ☐ Histology/Histopathology **(GO TO C11)**
- ☐ Cytology/Cytopathology **(GO TO C11)**
- ☐ Report exists but cannot be obtained **(COMPLETE C10)**

10. Verbatim Description of Primary Invasive Lung Cancer Diagnosis:
(COMPLETE ONLY WHEN ANSWER TO C9 IS "NO REPORT/CLINICAL EXAMINATION," or "REPORT EXISTS BUT CANNOT BE OBTAINED.")

11a. ICD-O-3 Cancer Classification: **(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)**

|_C_|___|___|___| - |___|___|___|___| - |___| - |___|
TOPOGRAPHY MORPHOLOGY BEHAVIOR GRADE

CTR ID #
(For Items C.11a, b, & C14-C17 only)
|___|___|___|___|

11b. Source: ☐ Cytology ☐ Histology ☐ Combined (CYTOLOGY and HISTOLOGY) ☐ Clinical
(IF COMBINED or CLINICAL, MUST COMMENT IN D.18)

12. Primary Tumor Location (**MARK ALL THAT APPLY**):

- ☐ Right upper lobe
- ☐ Right middle lobe
- ☐ Right lower lobe
- ☐ Left upper lobe
- ☐ Left lower lobe
- ☐ Lingula
- ☐ Right hilum
- ☐ Left hilum
- ☐ Right main stem bronchus
- ☐ Left main stem bronchus
- ☐ Carina
- ☐ Mediastinum
- ☐ Unknown
- ☐ Other: **(SPECIFY):**_____

13. Pathology Lesion Size (maximum dimension): |__|__|__| mm

14a. Pathologic Type for Primary Invasive Lung Cancer: **(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)**

|___|___|___|___|/|___|

14b. Date of Pathologic Confirmation: |___|___| / |___|___|/ |___|___|___|___|

15. Grade of Primary Invasive Lung Cancer: **(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)**

- ☐ Grade cannot be assessed (GX)
- ☐ Well differentiated (G1)
- ☐ Moderately differentiated (G2)
- ☐ Poorly differentiated (G3)
- ☐ Undifferentiated (G4)
- ☐ Unspecified in pathology report
- ☐ Unknown – Pathology report missing

16. TNM Staging for Primary Invasive Lung Cancer: **(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)**

16a. TNM Clinical Staging:
(**MARK ONE BOX ONLY IN EACH COLUMN.**)

☐ YES ☐ NO

16b. TNM Pathological Staging:
(**MARK ONE BOX ONLY IN EACH COLUMN.**)

☐ YES ☐ NO

Neoadjuvant therapy prior to staging?

☐ YES ☐ NO

Primary Tumor (T) Codes:	Nodal Involvement (N) Codes:	Distant Metastases (M) Codes:	Primary Tumor (T) Codes:	Nodal Involvement (N) Codes:	Distant Metastases (M) Codes:
☐ T_x	☐ N_x	☐ M_x	☐ T_x	☐ N_x	☐ M_x
☐ T_0	☐ N_0	☐ M_0	☐ T_1	☐ N_0	☐ M_0
☐ T_1	☐ N_1	☐ M_1	☐ T_2	☐ N_1	☐ M_1
☐ T_2	☐ N_2	☐Not available	☐ T_3	☐ N_2	☐Not available
☐ T_3	☐ N_3		☐ T_4	☐ N_3	
☐ T_4	☐Not available		☐Not available	☐Not available	
☐Not available					

17. Record Stage: **COMPLETE ONLY IF ANY PART OF THE TNM PATHOLOGICAL STAGING IS UNKNOWN.**
(TO BE COMPLETED BY CTR OR CTR-ELIGIBLE STAFF)

Stage Only:

- ☐ Occult Carcinoma
- ☐ IA
- ☐ IB
- ☐ IIA
- ☐ IIB
- ☐ IIIA
- ☐ IIIB
- ☐ IV
- ☐ Not available

VALCSG (Small Cell only):

- ☐ Limited
- ☐ Extensive
- ☐ Not available

Summary Staging:

- ☐ Localized
- ☐ Regional
- ☐ Distant
- ☐ Not available

PART D: COMMENTS

18. Comments: ☐ No ☐ Yes **(SPECIFY)**

☐ **Continued**

PART E: HEALTH CARE PROVIDER/HOSPITAL LOCATION INFORMATION

19. HEALTH CARE PROVIDER FOR DIAGNOSTIC EVALUATION:

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

20. HOSPITAL OR CLINIC FOR DIAGNOSTIC EVALUATION:

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