Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial

Version No.: 07/01

MEDICAL RECORD ABSTRACT FORM
TREATMENT INFORMATION - PROSTATE (TIP2/TPQ2)

1. Date Abstracted: MO. DAY YEAR — 20

2. Abstractor ID #:

3. CTR ID#:

4. Study Year T0-T13: T

5. Purpose of Abstract:
- ○ Initial abstract
- ○ Re-abstract for QA

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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. RADIATION TREATMENT FOR PROSTATE CANCER:

○ No ○ Yes (COMPLETE TABLE BELOW) ○ Unknown

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

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PART A CONTINUED . . .

2. SURGICAL TREATMENT FOR PROSTATE 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 03 04 06 07 08 09 10 11 12 13 88 SPECIFY	01 02 03 04 06 07 08 09 10 11 12 13 88 SPECIFY	01 02 03 04 06 07 08 09 10 11 12 13 88 SPECIFY	01 02 03 04 06 07 08 09 10 11 12 13 88 SPECIFY
DATE OF SURGERY (MO. - DAY - YEAR)	MO. DAY YEAR	MO. DAY YEAR	MO. DAY YEAR	MO. DAY YEAR

SURGICAL PROCEDURE CODES

01 = Pelvic node dissection (lymphadenectomy), surgical
02 = Pelvic node dissection (lymphadenectomy), laparoscopic
03 = Radical prostatectomy, perineal
04 = Radical prostatectomy, retropubic
06 = Subtotal/simple prostatectomy with lymph node dissection
07 = Subtotal/simple prostatectomy without lymph node dissection
08 = Transurethral resection
09 = Cryosurgery
10 = Anatomic (unilateral nerve sparing) prostatectomy, retropubic
11 = Anatomic (bilateral nerve sparing) prostatectomy, retropubic
12 = Prostatectomy, NOS
13 = Laser prostatectomy
88 = Other (SPECIFY)

3. HORMONAL TREATMENT FOR PROSTATE CANCER:

○ No ○ Yes **(COMPLETE TABLE BELOW)** ○ Unknown

TREATMENT #	1	2	3
DATE HORMONAL TREATMENT BEGAN (MO. - DAY - YEAR)	MO. DAY YEAR	MO. DAY YEAR	MO. DAY YEAR

PART A CONTINUED . . .

4. OTHER TYPE OF TREATMENT FOR PROSTATE CANCER:

○ No ○ Yes (COMPLETE TABLE BELOW) ○ Unknown

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

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

○ No
○ Yes - Microscopic
○ Yes - Gross Tumor
○ Yes - Elevated PSA
○ 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)

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