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

<table>
<thead>
<tr>
<th>PROCEDURE #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF SURGICAL PROCEDURE (SEE SURGICAL PROCEDURE CODES BELOW. IF OTHER, SPECIFY)</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
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<tr>
<td>DATE OF SURGERY (MO.-DAY-YEAR)</td>
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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

<table>
<thead>
<tr>
<th>TREATMENT #</th>
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<tr>
<td>DATE RADIATION TREATMENT BEGAN (MO.-DAY-YEAR)</td>
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3. CHEMOTHERAPEUTIC TREATMENT FOR OVARIAN CANCER:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)
   ○ Unknown

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4. OTHER TYPE OF TREATMENT FOR OVARIAN CANCER:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)
   ○ Unknown

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<td>OTHER</td>
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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 # ______________________

b. Name: _________________________________________________________________________________

Address: _________________________________________________________________________________

City
State
ZIP Code

Telephone: (___) _________________________   Medical Record/Chart # ______________________

8. COMMENTS:

〇 No
〇 Yes (SPECIFY)

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