

## Follow-Up Form

### Acute Myeloid Leukemia (LAML)

**Instructions:** The Follow-up Form is to be completed 12 months after a case enters the Biospecimen Core Resource (BCR). All information provided on this form includes activity from the "Date of Last Contact" provided on the TCGA Enrollment Form to the most recent date of contact with the patient. This form should only be completed by the Tissue Source Site if updated information can be provided to TCGA. Please direct any questions to the Clinical Outreach team at the BCR.

**Please note the following definitions for the "Unknown" and "Not Evaluated" answer options on this form.**

**Unknown:** This answer option should only be selected if the TSS does not know this information after all efforts to obtain the data have been exhausted. If this answer option is selected for a question that is part of the TCGA required data set, the TSS must complete a discrepancy note providing a reason why the answer is unknown.

**Not Evaluated:** This answer option should only be selected by the TSS if it is known that the information being requested cannot be obtained. This could be because the test in question was never performed on the patient or the TSS knows that the information requested was never disclosed.

Tissue Source Site (TSS): \_\_\_\_\_ TSS Identifier: \_\_\_\_\_ TSS Unique Patient Identifier: \_\_\_\_\_

Completed By (Interviewer Name on OpenClinica): \_\_\_\_\_ Completed Date: \_\_\_\_\_

#### General Information

#	Data Element	Entry Alternatives	Working Instructions
1	Has this TSS received permission from the NCI to provide time intervals as a substitute for requested dates on this form?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please note that the time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box.  <i>Provided time intervals must begin with the date of initial pathologic diagnosis (i.e., biopsy or resection). Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</i>
2	Is this Patient Lost to Follow-up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the patient is lost to follow-up, as defined by the ACoS Commission on Cancer. This only includes cases where updated follow-up information has not been collected within the past 15 months and all efforts to contact the patient have been exhausted (this includes reviewing the Social Security death index). If the patient is lost to follow-up, the remaining questions can be left unanswered. <a href="#">61333</a>  <i>If the patient is <b>deceased</b> and a TCGA follow-up form has not yet been completed, the answer to this question should be "no," and the remaining applicable questions should be completed.</i>

#### Follow-Up Information

#	Data Element	Entry Alternatives	Working Instructions
3	Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had radiation therapy <i>for the sample submitted for TCGA. IF the patient did have radiation, the Radiation Supplemental Form should be completed.</i> <a href="#">2005312</a>
4	Transplantation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had a bone marrow transplant. <a href="#">3131750</a>
5	Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had pharmaceutical therapy <i>for the sample submitted for TCGA. IF the patient did have pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.</i> <a href="#">3397567</a>

## Follow-Up Form

### Acute Myeloid Leukemia (LAML)

#	Data Element	Entry Alternatives	Working Instructions
6	Vital Status (at date of last contact)	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	Indicate whether the patient was living or deceased at the date of last contact. <a href="#">2939553</a>
<b>Date of Last Contact (If patient is living)</b>			
7	Month of Last Contact	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> 01</div> <div style="width: 50%;"><input type="checkbox"/> 04</div> <div style="width: 50%;"><input type="checkbox"/> 07</div> <div style="width: 50%;"><input type="checkbox"/> 10</div> <div style="width: 50%;"><input type="checkbox"/> 02</div> <div style="width: 50%;"><input type="checkbox"/> 05</div> <div style="width: 50%;"><input type="checkbox"/> 08</div> <div style="width: 50%;"><input type="checkbox"/> 11</div> <div style="width: 50%;"><input type="checkbox"/> 03</div> <div style="width: 50%;"><input type="checkbox"/> 06</div> <div style="width: 50%;"><input type="checkbox"/> 09</div> <div style="width: 50%;"><input type="checkbox"/> 12</div> </div>	If the patient is living, provide the month of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). <a href="#">2897020</a>
8	Day of Last Contact	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 20%;"><input type="checkbox"/> 01</div> <div style="width: 20%;"><input type="checkbox"/> 08</div> <div style="width: 20%;"><input type="checkbox"/> 14</div> <div style="width: 20%;"><input type="checkbox"/> 20</div> <div style="width: 20%;"><input type="checkbox"/> 26</div> <div style="width: 20%;"><input type="checkbox"/> 02</div> <div style="width: 20%;"><input type="checkbox"/> 09</div> <div style="width: 20%;"><input type="checkbox"/> 15</div> <div style="width: 20%;"><input type="checkbox"/> 21</div> <div style="width: 20%;"><input type="checkbox"/> 27</div> <div style="width: 20%;"><input type="checkbox"/> 03</div> <div style="width: 20%;"><input type="checkbox"/> 10</div> <div style="width: 20%;"><input type="checkbox"/> 16</div> <div style="width: 20%;"><input type="checkbox"/> 22</div> <div style="width: 20%;"><input type="checkbox"/> 28</div> <div style="width: 20%;"><input type="checkbox"/> 04</div> <div style="width: 20%;"><input type="checkbox"/> 11</div> <div style="width: 20%;"><input type="checkbox"/> 17</div> <div style="width: 20%;"><input type="checkbox"/> 23</div> <div style="width: 20%;"><input type="checkbox"/> 29</div> <div style="width: 20%;"><input type="checkbox"/> 05</div> <div style="width: 20%;"><input type="checkbox"/> 12</div> <div style="width: 20%;"><input type="checkbox"/> 18</div> <div style="width: 20%;"><input type="checkbox"/> 24</div> <div style="width: 20%;"><input type="checkbox"/> 30</div> <div style="width: 20%;"><input type="checkbox"/> 06</div> <div style="width: 20%;"><input type="checkbox"/> 13</div> <div style="width: 20%;"><input type="checkbox"/> 19</div> <div style="width: 20%;"><input type="checkbox"/> 25</div> <div style="width: 20%;"><input type="checkbox"/> 31</div> <div style="width: 20%;"><input type="checkbox"/> 07</div> </div>	If the patient is living, provide the day of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). <a href="#">2897022</a>
9	Year of Last Contact	_____	If the patient is living, provide the year of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). <a href="#">2897024</a>
10	Number of Days from Date of Initial Pathologic Diagnosis to Date of Last Contact	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of last contact. <a href="#">3008273</a>  <i>Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</i>
<b>Date of Death</b>			
11	Month of Death	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> 01</div> <div style="width: 50%;"><input type="checkbox"/> 04</div> <div style="width: 50%;"><input type="checkbox"/> 07</div> <div style="width: 50%;"><input type="checkbox"/> 10</div> <div style="width: 50%;"><input type="checkbox"/> 02</div> <div style="width: 50%;"><input type="checkbox"/> 05</div> <div style="width: 50%;"><input type="checkbox"/> 08</div> <div style="width: 50%;"><input type="checkbox"/> 11</div> <div style="width: 50%;"><input type="checkbox"/> 03</div> <div style="width: 50%;"><input type="checkbox"/> 06</div> <div style="width: 50%;"><input type="checkbox"/> 09</div> <div style="width: 50%;"><input type="checkbox"/> 12</div> </div>	If the patient is deceased, provide the month of death. <a href="#">2897026</a>
12	Day of Death	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 20%;"><input type="checkbox"/> 01</div> <div style="width: 20%;"><input type="checkbox"/> 08</div> <div style="width: 20%;"><input type="checkbox"/> 14</div> <div style="width: 20%;"><input type="checkbox"/> 20</div> <div style="width: 20%;"><input type="checkbox"/> 26</div> <div style="width: 20%;"><input type="checkbox"/> 02</div> <div style="width: 20%;"><input type="checkbox"/> 09</div> <div style="width: 20%;"><input type="checkbox"/> 15</div> <div style="width: 20%;"><input type="checkbox"/> 21</div> <div style="width: 20%;"><input type="checkbox"/> 27</div> <div style="width: 20%;"><input type="checkbox"/> 03</div> <div style="width: 20%;"><input type="checkbox"/> 10</div> <div style="width: 20%;"><input type="checkbox"/> 16</div> <div style="width: 20%;"><input type="checkbox"/> 22</div> <div style="width: 20%;"><input type="checkbox"/> 28</div> <div style="width: 20%;"><input type="checkbox"/> 04</div> <div style="width: 20%;"><input type="checkbox"/> 11</div> <div style="width: 20%;"><input type="checkbox"/> 17</div> <div style="width: 20%;"><input type="checkbox"/> 23</div> <div style="width: 20%;"><input type="checkbox"/> 29</div> <div style="width: 20%;"><input type="checkbox"/> 05</div> <div style="width: 20%;"><input type="checkbox"/> 12</div> <div style="width: 20%;"><input type="checkbox"/> 18</div> <div style="width: 20%;"><input type="checkbox"/> 24</div> <div style="width: 20%;"><input type="checkbox"/> 30</div> <div style="width: 20%;"><input type="checkbox"/> 06</div> <div style="width: 20%;"><input type="checkbox"/> 13</div> <div style="width: 20%;"><input type="checkbox"/> 19</div> <div style="width: 20%;"><input type="checkbox"/> 25</div> <div style="width: 20%;"><input type="checkbox"/> 31</div> <div style="width: 20%;"><input type="checkbox"/> 07</div> </div>	If the patient is deceased, provide the day of death. <a href="#">2897028</a>
13	Year of Death	_____	If the patient is deceased, provide the year of death. <a href="#">2897030</a>
14	Number of Days from Date of Initial Pathologic Diagnosis to Date of Death	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of death. <a href="#">3165475</a>  <i>Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</i>
15	Measure of success of outcome <i>at the completion of initial first course treatment</i>	<input type="checkbox"/> Persistent Disease <input type="checkbox"/> Complete Remission <input type="checkbox"/> Patient Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable	Provide the patient's response to their initial first course treatment. <a href="#">2786727</a>
16	Measure of Success of Outcome <i>at Completion of this Follow-up Form</i>	<input type="checkbox"/> Persistent Disease <input type="checkbox"/> Complete Remission <input type="checkbox"/> Patient Deceased <input type="checkbox"/> Unknown	Indicate the patient's measure of success at the time this follow-up form is completed. <a href="#">3033278</a>
17	Time to Neutrophil Recovery	_____ days (days to ANC >1000 per mcl)	Provide the number of days required for the patient's neutrophil count to recover to at least 1000 per cubic millimeter. <a href="#">3138062</a>
18	Time to Platelet Recovery	_____ days (days to platelet count >100,000 per mcl)	Provide the number of days required for the patient's platelet count to recover to at least 100,000 per cubic milliliter. <a href="#">3138066</a>

## Follow-Up Form

### Acute Myeloid Leukemia (LAML)

#	Data Element	Entry Alternatives	Working Instructions
19	Performance Status Scale: Karnofsky Score (To be taken prior to surgery/treatment)	<input type="checkbox"/> 100 – Normal, no complaints, no evidence of disease <input type="checkbox"/> 90 – Able to carry on normal activity; minor signs or symptoms of disease <input type="checkbox"/> 80 – Normal activity with effort; some signs or symptoms of disease <input type="checkbox"/> 70 – Cares for self, unable to carry on normal activity or to do active work <input type="checkbox"/> 60 – Requires occasional assistance, but is able to care for most of his/her needs <input type="checkbox"/> 50 – Requires considerable assistance and frequent medical care <input type="checkbox"/> 40 – Disabled, requires special care and assistance <input type="checkbox"/> 30 – Severely disabled, hospitalization indicated. Death is not imminent. <input type="checkbox"/> 20 – Very sick, hospitalization indicated. Death not imminent <input type="checkbox"/> 10 – Moribund, fatal processes progressing rapidly <input type="checkbox"/> 0 – Dead	Using the patient's medical records, provide the Karnofsky performance status score at the time provided in the "Timing" question below. <a href="#">2003853</a>
20	Performance Status Scale: Eastern Cooperative Oncology Group (ECOG) (To be taken prior to surgery/treatment)	<input type="checkbox"/> 0 – Asymptomatic <input type="checkbox"/> 1 – Symptomatic but fully ambulatory <input type="checkbox"/> 2 – Symptomatic but in bed less than 50% of the day <input type="checkbox"/> 3 – Symptomatic and in bed more than 50% of the day <input type="checkbox"/> 4 – Bedridden	Using the patient's medical records, provide the ECOG performance status score at the time provided in the "Timing" question below. <a href="#">88</a>
21	Performance Status Scale: Timing	<input type="checkbox"/> Induction <input type="checkbox"/> Salvage <input type="checkbox"/> Re-induction <input type="checkbox"/> Maintenance <input type="checkbox"/> Consolidation <input type="checkbox"/> Other, specify	Indicate the patient's status during the last documented ECOG and/or Karnofsky performance status score. <a href="#">2792763</a>
22	Other Performance Status Scale: Timing	_____	If the status of the patient during the last documented ECOG and/or Karnofsky performance score was not included in the provided list, specify the patient's status. <a href="#">3151756</a>

**New Tumor Event Information** Complete this section if the patient had a new tumor event. If the patient did not have a new tumor event (or if the TSS does not know) indicate this in the question below, and the remainder of this section can be skipped.

**Note:** The New Tumor Event section on OpenClinica can be completed multiple times, if the patient had multiple New Tumor Events.

#	Data Element	Entry Alternatives	Working Instructions
23	New Tumor Event After Initial Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after the date of initial diagnosis. <a href="#">3121376</a>  <i>If the patient did not have a new tumor event or if this is unknown, the remaining questions can be skipped.</i>
<b>Date of New Tumor Event after Initial Treatment</b>			
24	Month of New Tumor Event	<input type="checkbox"/> 01 <input type="checkbox"/> 04 <input type="checkbox"/> 07 <input type="checkbox"/> 10 <input type="checkbox"/> 02 <input type="checkbox"/> 05 <input type="checkbox"/> 08 <input type="checkbox"/> 11 <input type="checkbox"/> 03 <input type="checkbox"/> 06 <input type="checkbox"/> 09 <input type="checkbox"/> 12	If the patient had a new tumor event, provide the month of diagnosis for this new tumor event. <a href="#">3104044</a>
25	Day of New Tumor Event	<input type="checkbox"/> 01 <input type="checkbox"/> 08 <input type="checkbox"/> 14 <input type="checkbox"/> 20 <input type="checkbox"/> 26 <input type="checkbox"/> 02 <input type="checkbox"/> 09 <input type="checkbox"/> 15 <input type="checkbox"/> 21 <input type="checkbox"/> 27 <input type="checkbox"/> 03 <input type="checkbox"/> 10 <input type="checkbox"/> 16 <input type="checkbox"/> 22 <input type="checkbox"/> 28 <input type="checkbox"/> 04 <input type="checkbox"/> 11 <input type="checkbox"/> 17 <input type="checkbox"/> 23 <input type="checkbox"/> 29 <input type="checkbox"/> 05 <input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 <input type="checkbox"/> 30 <input type="checkbox"/> 06 <input type="checkbox"/> 13 <input type="checkbox"/> 19 <input type="checkbox"/> 25 <input type="checkbox"/> 31 <input type="checkbox"/> 07	If the patient had a new tumor event, provide the day of diagnosis for this new tumor event. <a href="#">3104042</a>
26	Year of New Tumor Event	_____	If the patient had a new tumor event, provide the year of diagnosis for this new tumor event. <a href="#">3104046</a>

## Follow-Up Form

### Acute Myeloid Leukemia (LAML)

#	Data Element	Entry Alternatives	Working Instructions
27	Number of Days from Date of Initial Pathologic Diagnosis to Date of New Tumor Event After Initial Treatment	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of new tumor event after initial treatment. <a href="#">3392464</a> <i>Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</i>
28	Type of New Tumor Event	<input type="checkbox"/> Locoregional/Recurrence <input type="checkbox"/> Distant Metastasis <input type="checkbox"/> New Primary Tumor	Indicate whether the patient's new tumor event was a locoregional recurrence, a distant metastasis or a new primary tumor. <a href="#">3119721</a>
29	Site of New Tumor Event	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Brain <input type="checkbox"/> Lung <input type="checkbox"/> Bone <input type="checkbox"/> Liver <input type="checkbox"/> Other, specify _____	Indicate the site of this new tumor event. <a href="#">3108271</a>
30	Other Site of New Tumor Event	_____	If the site of the new tumor event is not included in the provided list, describe the site of this new tumor event. <a href="#">3128033</a>
31	Additional Surgery for New Tumor Event	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's medical records, indicate whether the patient had surgery for the new tumor event in question. <a href="#">3008755</a>
<i>Date of Additional Surgery for New Tumor Event (when applicable)</i>			
32	Month of Additional Surgery for New Tumor Event	<input type="checkbox"/> 01 <input type="checkbox"/> 04 <input type="checkbox"/> 07 <input type="checkbox"/> 10 <input type="checkbox"/> 02 <input type="checkbox"/> 05 <input type="checkbox"/> 08 <input type="checkbox"/> 11 <input type="checkbox"/> 03 <input type="checkbox"/> 06 <input type="checkbox"/> 09 <input type="checkbox"/> 12	If the patient had surgery for the new tumor event, provide the month this surgery was performed. <a href="#">2897038</a>
33	Day of Additional Surgery for New Tumor Event	<input type="checkbox"/> 01 <input type="checkbox"/> 08 <input type="checkbox"/> 14 <input type="checkbox"/> 20 <input type="checkbox"/> 26 <input type="checkbox"/> 02 <input type="checkbox"/> 09 <input type="checkbox"/> 15 <input type="checkbox"/> 21 <input type="checkbox"/> 27 <input type="checkbox"/> 03 <input type="checkbox"/> 10 <input type="checkbox"/> 16 <input type="checkbox"/> 22 <input type="checkbox"/> 28 <input type="checkbox"/> 04 <input type="checkbox"/> 11 <input type="checkbox"/> 17 <input type="checkbox"/> 23 <input type="checkbox"/> 29 <input type="checkbox"/> 05 <input type="checkbox"/> 12 <input type="checkbox"/> 18 <input type="checkbox"/> 24 <input type="checkbox"/> 30 <input type="checkbox"/> 06 <input type="checkbox"/> 13 <input type="checkbox"/> 19 <input type="checkbox"/> 25 <input type="checkbox"/> 31 <input type="checkbox"/> 07	If the patient had surgery for the new tumor event, provide the day this surgery was performed. <a href="#">2897040</a>
34	Year of Additional Surgery for New Tumor Event	_____	If the patient had surgery for the new tumor event, provide the year this surgery was performed. <a href="#">2897042</a>
35	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of additional surgery for new tumor event (loco-regional). <a href="#">3008335</a> <i>Only provide Interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</i>
36	Additional treatment for New Tumor Event: Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received radiation treatment for this new tumor event. <a href="#">3008761</a>
37	Additional treatment for New Tumor Event: Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received pharmaceutical treatment for this new tumor event. <a href="#">2650646</a>

Principal Investigator or Designee Signature

Print Name

Date