Ablation/Embolization Therapy Supplemental Form

Instructions: *The TCGA Ablation/Embolization Therapy Form acts as a supplemental form to the Follow-up form and are due at the time the Follow-up form is submitted to the BCR.*

Questions regarding this form should be directed to the Tissue Source Site's primary Clinical Outreach Contact 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: _____

Ablation Treatment(s)

#	Data Element	Entry Alternatives	Working Instructions
1	Was Ablation Performed?	☐ Yes ☐ No	Indicate whether the patient received ablation treatment. 3225709 Note: If ablation was not performed, all related questions can be skipped.
2	Type of Ablation Treatment	☐ Radiofrequency Ablation (RFA) ☐ Radiosurgical Ablation ☐ Ethanol Injection ☐ Microwave ☐ Other (please specify)	If the patient received ablation, indicate the type. 3225702
3	Other Type of Ablation	_____	If the type of ablation received was not included in the provided list, describe the type of ablation. 3225705
4	Number of Treatments	_____	Indicate the number of treatments received for this type of ablation. 2199
5	Month Ablation Treatment Performed	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	Provide the month the ablation treatment was performed. 3225707
6	Day Ablation Treatment Performed	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	Provide the day the ablation treatment was performed. 3225706
7	Year Ablation Treatment Performed	_____	Provide the year the ablation treatment was performed. 3225708
8	Number of Lesions	_____	Provide the number of lesions treated with ablation. 3225710

Embolization Treatment(s)

#	Data Element	Entry Alternatives	Working Instructions
1	Was Embolization Performed?	☐ Yes ☐ No	Indicate whether the patient received embolization treatment. 3225713 Note: If Embolization was not performed, all related questions can be skipped.
2	Embolization Treatment	☐ Chemoembolization ☐ Radioembolization	If the patient received embolization, indicate the type. 3225722
3	Month Embolization Treatment Performed	☐ 01 ☐ 04 ☐ 07 ☐ 10 ☐ 02 ☐ 05 ☐ 08 ☐ 11 ☐ 03 ☐ 06 ☐ 09 ☐ 12	Provide the month the embolization treatment was performed. 3225715
4	Day Embolization Treatment Performed	☐ 01 ☐ 08 ☐ 14 ☐ 20 ☐ 26 ☐ 02 ☐ 09 ☐ 15 ☐ 21 ☐ 27 ☐ 03 ☐ 10 ☐ 16 ☐ 22 ☐ 28 ☐ 04 ☐ 11 ☐ 17 ☐ 23 ☐ 29 ☐ 05 ☐ 12 ☐ 18 ☐ 24 ☐ 30 ☐ 06 ☐ 13 ☐ 19 ☐ 25 ☐ 31 ☐ 07	Provide the day the embolization treatment was performed. 3225714
5	Year Embolization Treatment Performed	_____	Provide the year the embolization treatment was performed. 3225716
6	Drug Name	☐ Doxorubicin ☐ Mitomycin C ☐ Cisplatin ☐ Other (please specify)	If the patient received embolization, select the name of the drug used. 3225736
7	Other Drug Name	_____	If the patient received embolization and the name of the drug is not provided in the list, specify the drug name. 2975232
8	Embolizing Agent Utilized	☐ Gelfoam ☐ Plastic Beads ☐ Y-90 Therasphere ☐ Y-90 Sirsphere ☐ Other (please specify)	If the patient received embolization, select the name of the agent used. 3247288
9	Other Embolizing Agent Utilized	_____	If the patient received embolization, and the name of the agent used is not included in the provided list, specify the agent. 3225739

_____ _____ __ __/ __ __/ __ __ __ __

Principal Investigator or Designee Signature | Print Name | Date