

# Enrollment Form Bladder (BLCA)

**Instructions:** The Enrollment Form should be completed for each TCGA qualified case, upon qualification notice from the BCR. All information provided on this form should include activity from the date of initial diagnosis to the most recent date of contact with the patient ("Date of Initial Pathologic Diagnosis" and "Date of Last Contact" on this form).

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 in 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	If the answer to this question is yes, time intervals must be provided instead of dates, as indicated throughout this form.  <i>Provided time intervals must begin with the date of initial pathologic diagnosis (e.g. biopsy). 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 a prospective tissue collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the TSS providing tissue is contracted for prospective tissue collection. If the submitted tissue was collected for the specific purpose of TCGA, the tissue has been collected prospectively. <a href="#">3088492</a>
3	Is this a retrospective tissue collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the TSS providing tissue is contracted for retrospective tissue collection. If the submitted tissue was collected prior to the date the TCGA contract was executed, the tissue has been collected retrospectively. <a href="#">3088528</a>

## Patient Information

#	Data Element	Entry Alternatives	Working Instructions
<b>Date of Birth</b>			
4	Month of Birth	<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	Provide the month the patient was born. <a href="#">2896950</a>
5	Day of Birth	<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	Provide the day the patient was born. <a href="#">2896952</a>
6	Year of Birth	_____	Provide the year the patient was born. <a href="#">2896954</a>

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#	Data Element	Entry Alternatives	Working Instructions
7	Number of Days from Date of Initial Pathologic Diagnosis to Date of Birth	_____	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of birth. <a href="#">3008233</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>
8	Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Provide the patient's gender using the defined categories. <a href="#">2200604</a>
9	Height (at time of diagnosis)	_____ (cm)	Provide the patient's height (in centimeters) at the time the patient was diagnosed with the malignancy being submitted for TCGA. <a href="#">649</a>
10	Weight (at time of diagnosis)	_____ (kg)	Provide the patient's weight (in kilograms) at the time the patient was diagnosed with the malignancy being submitted for TCGA. <a href="#">651</a>
11	Race	<input type="checkbox"/> American Indian or Alaska Native <i>A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.</i> <input type="checkbox"/> Asian <i>A person having origins in any of the original peoples of the far East, Southeast Asia, or in the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</i> <input type="checkbox"/> White <i>A person having origins in any of the original peoples of the far Europe, the Middle East, or North Africa.</i> <input type="checkbox"/> Black or African American <i>A person having origins in any of any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."</i> <input type="checkbox"/> Native Hawaiian or other Pacific Islander: <i>A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</i> <input type="checkbox"/> Not Evaluated <i>Not provided or available.</i> <input type="checkbox"/> Unknown <i>Could not be determined or unsure.</i>	Provide the patient's race using the defined categories. <a href="#">2192199</a>
12	Ethnicity	<input type="checkbox"/> Not Hispanic or Latino: <i>A person not meeting the definition of Hispanic or Latino.</i> <input type="checkbox"/> Hispanic or Latino: <i>A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.</i> <input type="checkbox"/> Not Evaluated <i>Not provided or available.</i> <input type="checkbox"/> Unknown <i>Could not be determined or unsure.</i>	Provide the patient's ethnicity using the defined categories. <a href="#">2192217</a>
13	History of Prior Malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the patient was, at any time in their life, diagnosed with a malignancy prior to the diagnosis of the specimen submitted for TCGA. If the patient has had a prior malignancy, an additional form (the "Other Malignancy Form") must be completed for each prior malignancy. If the OMF was completed and submitted with the Initial Case Quality Control Form, the OMF does not need to be submitted a second time. <a href="#">3382736</a> <i>If this question cannot be answered because the answer is unknown, the case will be excluded from TCGA.</i> <i>If the patient has a history of multiple diagnoses of basal or squamous cell skin cancer, complete an OMF for the first diagnosis for each of these types.</i>

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#	Data Element	Entry Alternatives	Working Instructions
14	History of Neo-adjuvant Treatment for Sample Submitted for TCGA	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the patient received neo-adjuvant treatment (radiation, pharmaceutical, or both) prior to the collection of the sample submitted for TCGA. <a href="#">3382737</a> <i>Systemic therapy and certain localized therapies (those administered to the same site as the TCGA submitted sample) given prior to the collection of the sample submitted for TCGA is exclusionary.</i> <i>BCG treatment prior to procurement is acceptable, if administered at least 90 days prior to tumor procurement.</i>
15	Does the patient have a history of non-muscle invasive bladder cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient has a history of non-muscle invasive bladder cancer. <a href="#">3436253</a>
16	If the patient does have a history of non-muscle invasive bladder cancer, how was the patient treated? <i>Check all that apply</i>	<input type="checkbox"/> Transurethral resection alone <input type="checkbox"/> Bacillus Calmette-Guerin (BCG) <input type="checkbox"/> No treatment	If the patient has a history of non-muscle invasive bladder cancer, indicate the type of treatment given for the non-muscle tumor. <a href="#">3436357</a> <i>Note: Intravesical chemotherapy is not allowable.</i>
17	If this patient received BCG treatment, was it given within 90 days from the resection date of the muscle invasive bladder tumor submitted for TCGA?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If the patient received BCG treatment for the tumor submitted for TCGA, indicate whether this treatment was given within 90 days of the resection of this tumor. <a href="#">3436260</a>
18	If this patient received BCG treatment, did the patient have a complete response?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If the patient received BCG treatment, indicate whether the patient had a complete response. A complete response includes normal cytology, normal cytology, and a negative biopsy (if performed). <a href="#">3436262</a>
19	If this patient received BCG treatment, did the patient complete one or more induction courses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If the patient received BCG treatment, indicate whether the patient completed one or more induction courses. <a href="#">3436265</a>
20	If this patient received BCG treatment, did the patient complete one or more maintenance courses?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If the patient received BCG treatment, indicate whether the patient completed one or more maintenance courses. <a href="#">3436266</a>
21	If this patient received BCG treatment and had a complete response, how long was this maintained from the first BCG instillation?	____ months	If the patient received BCG treatment, provide the number of months the complete response was maintained, beginning with the initial date that complete response was documented. <a href="#">3436267</a>
22	Tumor Status (at time of last contact or death)	<input type="checkbox"/> Tumor free <input type="checkbox"/> With tumor <input type="checkbox"/> Unknown	Indicate whether the patient was tumor/disease free at the date of last contact or death. <a href="#">2759550</a>
23	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</b> (If patient is living)			
24	Month of Last Contact	<div style="display: flex; flex-wrap: wrap;"> <div style="margin-right: 10px;"><input type="checkbox"/> 01</div> <div style="margin-right: 10px;"><input type="checkbox"/> 04</div> <div style="margin-right: 10px;"><input type="checkbox"/> 07</div> <div style="margin-right: 10px;"><input type="checkbox"/> 10</div> <div style="margin-right: 10px;"><input type="checkbox"/> 02</div> <div style="margin-right: 10px;"><input type="checkbox"/> 05</div> <div style="margin-right: 10px;"><input type="checkbox"/> 08</div> <div style="margin-right: 10px;"><input type="checkbox"/> 11</div> <div style="margin-right: 10px;"><input type="checkbox"/> 03</div> <div style="margin-right: 10px;"><input type="checkbox"/> 06</div> <div style="margin-right: 10px;"><input type="checkbox"/> 09</div> <div style="margin-right: 10px;"><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> <i>Do not answer if patient is deceased.</i>

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#	Data Element	Entry Alternatives	Working Instructions
25	Day of Last Contact	<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	<p>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></p> <p><i>Do not answer if patient is deceased.</i></p>
26	Year of Last Contact	_____	<p>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></p> <p><i>Do not answer if patient is deceased.</i></p>
27	Number of Days from Date of Initial Pathologic Diagnosis to Date of Last Contact	_____	<p>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></p> <p><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></p>
<b>Date of Death</b>			
28	Month of Death	<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	<p>If the patient is deceased, provide the month of death.  <a href="#">2897026</a></p>
29	Day of Death	<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	<p>If the patient is deceased, provide the day of death.  <a href="#">2897028</a></p>
30	Year of Death	_____	<p>If the patient is deceased, provide the year of death.  <a href="#">2897030</a></p>
31	Number of Days from Date of Initial Pathologic Diagnosis to Date of Death	_____	<p>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></p> <p><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></p>
32	Current Occupation	_____	<p>Provide the patient's current occupation or their occupation at death. Current occupations can include homemaker, student, or retired.  <a href="#">2435398</a></p>
33	Primary Occupation	_____	<p>Provide the occupation in which the patient was employed for the majority of their working years. Primary occupations can include homemaker and student.  <a href="#">5714</a></p>
34	Primary Occupation: Chemical Exposure	_____	<p>Provide any chemical exposure the patient had during their working years in their primary occupation.  <a href="#">2596673</a></p>
35	Primary Occupation: In what type of industry was the patient employed?	_____	<p>Provide the industry of the patient's primary occupation.  <a href="#">3135408</a></p>
36	Primary Occupation: How many years has the patient worked in this occupation?	_____	<p>Provide the number of years the patient was employed in their primary occupation.  <a href="#">2435424</a></p>

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#	Data Element	Entry Alternatives	Working Instructions																
37	Tobacco smoking history indicator	<input type="checkbox"/> 1-Lifelong non-smoker (<100 cigarettes smoked in lifetime) <input type="checkbox"/> 2-Current smoker (includes daily and non-daily smokers) <input type="checkbox"/> 3-Current reformed smoker for > 15 years <input type="checkbox"/> 4-Current reformed smoker for <= 15 years <input type="checkbox"/> 5-Current reformed smoker (duration not specified) <input type="checkbox"/> Smoking History not Documented	Indicate the patient's history of tobacco smoking as well as their current smoking status using the defined categories. If the patient is a lifelong non-smoker, skip the additional smoking questions. <a href="#">2181650</a>																
38	Age of onset tobacco smoking	<div style="text-align: center;">____ Years of Age</div>	Provide the age in years when the patient began smoking cigarettes. <a href="#">2178045</a> <i>If the patient is a lifelong non-smoker, do not answer this question.</i>																
39	Year of quitting tobacco smoking	<div style="text-align: center;">____ (YYYY)</div>	Provide the year the patient quit smoking. <a href="#">2228610</a> <i>If the patient is a lifelong non-smoker or if the patient has not quit smoking, do not answer this question.</i>																
40	Number of Pack Years Smoked	<div style="text-align: center;">____ Years</div>	Provide the number of pack years the patient smoked. This is calculated using the number of cigarettes smoked per day times the number of years smoked, divided by 20. For example, if a patient smoked 5 cigarettes per day times 10 years divided by 20, the patient would have 2.5 pack years (e.g. 5 x 10/ 20=2.5). <a href="#">2955385</a> <i>If the patient is a lifelong non-smoker, do not answer this question.</i>																
41	Blood Relative Cancer History	<table border="1"> <thead> <tr> <th>Relative</th><th>Cancer Type</th></tr> </thead> <tbody> <tr><td>Mother</td><td></td></tr> <tr><td>Father</td><td></td></tr> <tr><td>Grandmother</td><td></td></tr> <tr><td>Grandfather</td><td></td></tr> <tr><td>Sister</td><td></td></tr> <tr><td>Brother</td><td></td></tr> <tr><td>Child</td><td></td></tr> </tbody> </table>	Relative	Cancer Type	Mother		Father		Grandmother		Grandfather		Sister		Brother		Child		Provide any first degree blood relatives with a known history of cancer. <a href="#">2783641</a> Provide the cancer diagnosis of any known relatives with a history cancer. <a href="#">2195089</a>
Relative	Cancer Type																		
Mother																			
Father																			
Grandmother																			
Grandfather																			
Sister																			
Brother																			
Child																			
42	Adjuvant (Post-Operative) Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had adjuvant/ post-operative radiation therapy. <b><i>IF the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.</i></b> <a href="#">2005312</a>																
43	Adjuvant (Post-Operative) Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy. <b><i>IF the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.</i></b> <a href="#">3397567</a>																
44	Measure of success of outcome <u>at the completion of initial first course treatment</u>	<input type="checkbox"/> Progressive Disease <input type="checkbox"/> Stable Disease <input type="checkbox"/> Partial Response <input type="checkbox"/> Complete Response <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable	Provide the patient's response to their initial first course treatment. <a href="#">2786727</a>																

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#	Data Element	Entry Alternatives	Working Instructions
45	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 <input type="checkbox"/> ECOG has been provided; Karnofsky Score not required. <input type="checkbox"/> Unknown <input type="checkbox"/> Not Evaluated	Provide either the Karnofsky or the ECOG performance status score. If the ECOG performance score is provided, select the last answer option. <a href="#">2003853</a>
46	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 <input type="checkbox"/> Karnofsky Score has been provided; ECOG not required. <input type="checkbox"/> Unknown <input type="checkbox"/> Not Evaluated	Provide either the Karnofsky or the ECOG performance status score. If the Karnofsky performance score is provided, select the last answer option. <a href="#">88</a>

### Pathologic/Prognostic Information

#	Data Element	Entry Alternatives	Working Instructions
47	Primary Site of Disease	<input type="checkbox"/> Bladder	Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for TCGA. <a href="#">2735776</a>
48	Histological Subtype	<input type="checkbox"/> Muscle invasive urothelial carcinoma (pT2 or above)	Using the patient's pathology/laboratory report, select the histology and/or subtype of the tumor submitted for TCGA. <a href="#">2831122</a>
49	Diagnosis subtype	<input type="checkbox"/> Papillary <input type="checkbox"/> Non-papillary	Using the patient's pathology/laboratory report, indicate whether the disease was papillary or non-papillary. <a href="#">2783887</a>
50	Tumor Grade	<input type="checkbox"/> Low Grade <input type="checkbox"/> High Grade <input type="checkbox"/> Unknown	Using the patient's pathology/laboratory report, select the tumor grade. <a href="#">2867375</a>  <i>If the following descriptions are used for grade, please assign the provided grade as noted below:</i> <ul style="list-style-type: none"> <li>• GX (Grade cannot be assessed) = Unknown</li> <li>• G1 (Well differentiated) = Low Grade</li> <li>• G2 (Moderately differentiated) = High Grade</li> <li>• G3 (Poorly differentiated) = High Grade</li> <li>• G4 (Undifferentiated) = High Grade</li> </ul>

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#	Data Element	Entry Alternatives	Working Instructions
51	Anatomic Organ Sub-Division <i>Check all that apply</i>	<input type="checkbox"/> Bladder, NOS <input type="checkbox"/> Dome <input type="checkbox"/> Neck <input type="checkbox"/> Trigone <input type="checkbox"/> Wall, NOS <input type="checkbox"/> Wall, anterior <input type="checkbox"/> Wall, lateral <input type="checkbox"/> Wall, posterior	Using the patient's pathology/laboratory report, select all areas of tumor invasion. <a href="#">2008006</a>
<b>Date and Method of Initial Pathologic Diagnosis</b>			
52	Month of Initial Pathologic Diagnosis	<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	Provide the month the patient was initially pathologically diagnosed with the malignancy submitted for TCGA. <a href="#">2896956</a>
53	Day of Initial Pathologic Diagnosis	<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	Provide the day the patient was initially pathologically diagnosed with the malignancy submitted for TCGA. <a href="#">2896958</a>
54	Year of Initial Pathologic Diagnosis	_____	Provide the year the patient was initially pathologically diagnosed with the malignancy submitted for TCGA. <a href="#">2896960</a>
55	Age at Initial Diagnosis	_____	Provide the age of the patient in years, at the time the patient was initially pathologically diagnosed. <a href="#">2006657</a>  <i>Only complete this question if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</i>
56	Method of Initial Pathologic Diagnosis	<input type="checkbox"/> Endoscopic biopsy <input type="checkbox"/> Transurethral resection (TURBT) <input type="checkbox"/> Other, specify _____	Provide the procedure used to initially diagnose the patient. <a href="#">2757941</a>  <i>Please note that this method is referring to the procedure performed on the Date of Initial Pathologic Diagnosis, provided in the previous question.</i>
57	Other Method of Pathologic Diagnosis	_____	If the procedure used to initially diagnose the patient was not included in the list provided, please describe the method used. <a href="#">2757948</a>
<b>AJCC Staging</b>			
58	AJCC Cancer Staging Edition	<input type="checkbox"/> 1 <sup>st</sup> Edition ( 1978-1983) <input type="checkbox"/> 2 <sup>nd</sup> Edition ( 1984-1988) <input type="checkbox"/> 3 <sup>rd</sup> Edition ( 1989-1992) <input type="checkbox"/> 4 <sup>th</sup> Edition ( 1993-1997) <input type="checkbox"/> 5 <sup>th</sup> Edition ( 1998-2002) <input type="checkbox"/> 6 <sup>th</sup> Edition ( 2003-2009) <input type="checkbox"/> 7 <sup>th</sup> Edition ( 2010-present)	Please select the AJCC Cancer Staging Edition used to answer the following questions. <a href="#">2722309</a>
59	Clinical Assessment (TURBT and EUA): Primary Tumor (T) <i>Complete this question in the absence of a cystectomy specimen. Please provide as much information as possible.</i>	<input type="checkbox"/> TX <input type="checkbox"/> T2b <input type="checkbox"/> T0 <input type="checkbox"/> T3, NOS <input type="checkbox"/> Tis <input type="checkbox"/> T3a <input type="checkbox"/> T1 <input type="checkbox"/> T3b <input type="checkbox"/> T2, NOS <input type="checkbox"/> T4, NOS <input type="checkbox"/> T2a <input type="checkbox"/> T4a <input type="checkbox"/> <input type="checkbox"/> T4b	Using the patient's pathology/laboratory report, select the code for the clinical T (primary tumor) defined by the American Joint Committee on Cancer (AJCC). <a href="#">3135236</a>
60	Pathologic Stage (for Cystectomy Specimen): Primary Tumor (pT) <i>Please provide as much information as possible.</i>	<input type="checkbox"/> pTX <input type="checkbox"/> pT2b <input type="checkbox"/> pT0 <input type="checkbox"/> pT3 <input type="checkbox"/> pTis <input type="checkbox"/> pT3a <input type="checkbox"/> pTa <input type="checkbox"/> pT3b <input type="checkbox"/> pT1 <input type="checkbox"/> pT4 <input type="checkbox"/> pT2 <input type="checkbox"/> pT4a <input type="checkbox"/> pT2a <input type="checkbox"/> pT4b	Using the patient's pathology/laboratory report, select the code for the pathologic T (primary tumor) defined by the American Joint Committee on Cancer (AJCC). <a href="#">3045435</a>
61	Lymphovascular Invasion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether large vessel (vascular) invasion and/or small, thin-walled (lymphatic) invasion was detected. <a href="#">64727</a>



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#	Data Element	Entry Alternatives	Working Instructions
62	Pathologic Spread( <i>for Cystectomy Specimen</i> ): Regional Nodes (pN)	<input type="checkbox"/> pNX <input type="checkbox"/> pN0 <input type="checkbox"/> pN1 <input type="checkbox"/> pN2 <input type="checkbox"/> pN3 <input type="checkbox"/> pN4	Using the patient's pathology/laboratory report, select the code for the pathologic N (nodal) defined by the American Joint Committee on Cancer (AJCC). <a href="#">3203106</a>
<b>Lymph Node Status</b> ( <i>Complete only if a lymphadenectomy was performed</i> )			
63	Were Lymph Nodes Examined at the Time of Primary Resection?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether any lymph nodes were examined at the time of the primary resection. <a href="#">2200396</a>
64	Number of Lymph Nodes Examined	_____	Provide the number of lymph nodes examined, if one or more lymph nodes were removed. <a href="#">3</a>
65	Number of lymph nodes positive by H&E light microscopy	_____	Provide the number of lymph nodes positive through hematoxylin and eosin (H&E) staining and light microscopy. <a href="#">3086388</a>
66	Extracapsular Extension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's pathology/laboratory report, indicate whether there was extracapsular extension. <a href="#">64165</a>
67	If Extracapsular Extension present	<input type="checkbox"/> Focal <input type="checkbox"/> Extensive <input type="checkbox"/> Unknown	If there was extracapsular extension present, indicate whether the extension was focal or extensive. If extracapsular extension was not present, skip this question. <a href="#">3130374</a>
68	Distant Spread: Distant Metastasis (M)	<input type="checkbox"/> MX <input type="checkbox"/> M0 <input type="checkbox"/> M1	Using the patient's pathology/laboratory report, select the code for the pathologic M (metastasis) defined by the American Joint Committee on Cancer (AJCC). <a href="#">3045439</a> <i>Please provide clinical evidence (often imaging) strong enough to determine patient treatment OR Histological confirmation when available.</i>
69	Metastatic Site ( <i>check all that apply</i> )	<input type="checkbox"/> Lymph node only <input type="checkbox"/> Lung <input type="checkbox"/> Liver <input type="checkbox"/> Bone <input type="checkbox"/> Other, specify <input type="checkbox"/> None	If the patient had a metastatic tumor at the time of initial diagnosis of the tumor submitted for TCGA, provide the site of the metastasis. If there was more than one metastatic site, select all that apply. <a href="#">62835</a>
70	Other Metastatic Site	_____	If the site of the metastasis was not included in the list provided, please provide the site. <a href="#">3135371</a>
71	Tumor Stage	<input type="checkbox"/> Stage 0a <input type="checkbox"/> Stage 0is <input type="checkbox"/> Stage 0 <input type="checkbox"/> Stage I <input type="checkbox"/> Stage II <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV	Using the patient's pathology/laboratory report, select the stage defined by the American Joint Committee on Cancer (AJCC). <a href="#">3203222</a>
72	Did the patient have incidental prostate cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's pathology/laboratory report, indicate whether incidental prostate cancer was found at the time of the bladder cancer diagnosis. If there was no incidental prostate cancer, skip any related questions. <a href="#">3135387</a>
73	Pathologic Spread for Incidental Prostate Cancer	<input type="checkbox"/> pTX <input type="checkbox"/> pT0 <input type="checkbox"/> pT1, NOS <input type="checkbox"/> pT1a <input type="checkbox"/> pT1b <input type="checkbox"/> pT1c <input type="checkbox"/> pT2, NOS <input type="checkbox"/> pT2a <input type="checkbox"/> pT2b <input type="checkbox"/> pT2c <input type="checkbox"/> pT3, NOS <input type="checkbox"/> pT3a <input type="checkbox"/> pT3b <input type="checkbox"/> pT4	If incidental prostate cancer was discovered, select the code for the pathologic T (primary tumor) defined by the American Joint Committee on Cancer (AJCC). <a href="#">3135398</a>
74	Gleason Score ( <i>If patient had incidental prostate cancer</i> )	<input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> Unknown	If incidental prostate cancer was discovered, select the Gleason score (a prognostic measure obtained by adding the primary and secondary patterns) for the prostate cancer. <a href="#">2634976</a>



## Enrollment Form Bladder (BLCA)

**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.

#	Data Element	Entry Alternatives	Working Instructions
75	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>
<i>Date of New Tumor Event after Initial Treatment</i>			
76	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>
77	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>
78	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>
79	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>
80	Type of New Tumor Event	<input type="checkbox"/> Locoregional ( <i>Urothelial tumor event</i> ) <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>
81	Site of New Tumor Event	<input type="checkbox"/> Renal Pelvis <input type="checkbox"/> Lung <input type="checkbox"/> Ureter <input type="checkbox"/> Liver <input type="checkbox"/> Bladder <input type="checkbox"/> Bone <input type="checkbox"/> Urethra <input type="checkbox"/> Other, specify <input type="checkbox"/> Lymph Node Only	If the patient had a new tumor event, provide the site of this tumor. <a href="#">3108271</a>
82	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>
83	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="#">3427611</a>
<i>Date of Additional Surgery for New Tumor Event (when applicable)</i>			
84	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="#">3427612</a>
85	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="#">3427613</a>
86	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="#">3427614</a>

**Enrollment Form**  
**Bladder (BLCA)**

#	Data Element	Entry Alternatives	Working Instructions
	Event		
<u>87</u>	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event	<hr/>	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>
<u>88</u>	Additional treatment for New Tumor Event: <i>Radiation Therapy</i>	<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="#">3427615</a>
<u>89</u>	Additional treatment for New Tumor Event: <i>Pharmaceutical Therapy</i>	<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="#">3427616</a>

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Principal Investigator or Designee Signature

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Print Name

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Date