Follow-Up Form
Mesothelioma

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*	Is this Patient Lost to Follow-up?	☐ Yes ☐ 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. 61333 *If the patient is **deceased** 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.*

Follow-Up Information

#	Data Element	Entry Alternatives	Working Instructions
2*	Adjuvant (Post-Operative) Radiation Therapy	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had adjuvant/ post-operative radiation therapy. ***IF the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed***. 2005312
3*	Adjuvant (Post-Operative) Pharmaceutical Therapy	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy. ***IF the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed***. 3397567
4	Tumor Status *(at time of last contact or death)*	☐ Tumor free ☐ With tumor ☐ Unknown	Indicate whether the patient was tumor/disease free at the date of last contact or death. 2759550
5*	Vital Status *(at date of last contact)*	☐ Living ☐ Deceased	Indicate whether the patient was living or deceased at the date of last contact. 2939553
Date of Last Contact *(If patient is living)*			
6	Date of Last Contact	___ ___ ___ ___ ___ ___ ___ ___ *Month* *Day* *Year*	If the patient is living, provide the date of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897020 (Month), 2897022 (Day), 2897024 (Year)
Date of Death			
7	Date of Death	___ ___ ___ ___ ___ ___ ___ ___ *Month* *Day* *Year*	If the patient is deceased, provide the date of death. 2897026 (Month), 2897028 (Day), 2897030 (Year)

#	Data Element	Entry Alternatives	Working Instructions
8	Performance Status Scale: Karnofsky Score *(To be taken prior to surgery/treatment)*	☐ 100 – Normal, no complaints, no evidence of disease ☐ 90 – Able to carry on normal activity; minor signs or symptoms of disease ☐ 80 – Normal activity with effort; some signs or symptoms of disease ☐ 70 – Cares for self, unable to carry on normal activity or to do active work ☐ 60 – Requires occasional assistance, but is able to care for most of his/her needs ☐ 50 – Requires considerable assistance and frequent medical care ☐ 40 – Disabled, requires special care and assistance ☐ 30 – Severely disabled, hospitalization indicated. Death is not imminent. ☐ 20 – Very sick, hospitalization indicated. Death not imminent ☐ 10 – Moribund, fatal processes progressing rapidly ☐ 0 – Dead ☐ Unknown ☐ Not Evaluated	Using the patient's medical records, provide the Karnofsky performance status score at the time provided in the "Timing" question below. 2003853
9	Performance Status Scale: Eastern Cooperative Oncology Group (ECOG) *(To be taken prior to surgery/treatment)*	☐ 0 – Asymptomatic ☐ 1 – Symptomatic but fully ambulatory ☐ 2 – Symptomatic but in bed less than 50% of the day ☐ 3 – Symptomatic and in bed more than 50% of the day ☐ 4 – Bedridden ☐ Unknown ☐ Not Evaluated	Using the patient's medical records, provide the ECOG performance status score at the time provided in the "Timing" question below. 88
10	Performance Status Scale: Timing	☐ Pre-Operative ☐ Pre-Adjuvant therapy ☐ Post-Adjuvant therapy ☐ Other ☐ Unknown	Indicate the patient's status during the last documented ECOG and/or Karnofsky performance status score. 2792763
11	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. 3151756

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
12*	New Tumor Event After Initial Treatment?	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after the date of initial diagnosis. For mesothelioma, recurrent tumor is local progression in or adjacent to the original cavity and metastatic means disease outside the original pleural cavity. 3121376 *If the patient did not have a new tumor event or if this is unknown, the remaining questions can be skipped.*
Date of New Tumor Event after Initial Treatment			
13	Date of New Tumor Event	___ ___ ___ ___ ___ ___ ___ ___ *Month* *Day* *Year*	If the patient had a new tumor event, provide the date of diagnosis for this new tumor event. 3104044 (Month), 3104042 (Day), 3104046 (Year)

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#	Data Element	Entry Alternatives	Working Instructions
14	Type of New Tumor Event	☐ Intrapleural Progression ☐ Distant Metastasis ☐ New Primary Tumor	Indicate whether the patient's new tumor event was a locoregional recurrence, a distant metastasis or a new primary tumor. 3119721
15	Site of New Tumor Event	☐ Brain ☐ Lung ☐ Unknown ☐ Liver ☐ Other, specify ☐ Bone	Indicate the site of this new tumor event. 3108271
16	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. 3128033
17	Additional Surgery for New Tumor Event	☐ Yes ☐ No ☐ Unknown	Using the patient's medical records, indicate whether the patient had surgery for the new tumor event in question. 3427611
Date of Additional Surgery for New Tumor Event (when applicable)			
18	Date of Additional Surgery for New Tumor Event	___ ___ ___ ___ ___ ___ ___ ___ *Month* *Day* *Year*	If the patient had surgery for the new tumor event, provide the date this surgery was performed. 3427612 (Month), 3427613 (Day), 3427614 (Year)
19	Additional treatment for New Tumor Event: *Radiation Therapy*	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient received radiation treatment for this new tumor event. 3427615
20	Additional treatment for New Tumor Event: *Pharmaceutical Therapy*	☐ Yes ☐ No ☐ Unknown	Indicate whether the patient received pharmaceutical treatment for this new tumor event. 3427616

_____ _____ ___ ___/ ___ ___/ ___ ___ ___ ___

Principal Investigator or Designee Signature | Print Name | Date