

Tissue Source Site (TSS) Name: _____ TSS Identifier: _____ TSS Unique Patient #: _____

Completed By: _____ Completion Date (MM/DD/YYYY): _____

Form Notes: A Follow-up Form is to be completed for any of the following reasons: 1) For each additional new tumor event identified at the time of enrollment or follow-up submission; or 2) 12 months after a case is shipped to the Biospecimen Core Resource (BCR) for cases that have qualified. 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. Questions regarding this form should be directed to the Tissue Source Site's (TSS) primary Clinical Outreach Contact at the BCR.

The following definitions for the use of "Unknown" and "Not Evaluated" on this form are as follows:

Unknown: This answer option should only be selected if the TSS cannot answer the question because the answer is not known at the TSS. 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 the reason why the answer is unknown.

Not Evaluated: This answer option should be selected by the TSS if it is known that the information being requested cannot be obtained due to the test not being performed.

Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
1	Has this TSS received permission from 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 time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box to the left. Note 1: Provided time intervals must begin with the date of initial pathologic diagnosis. (i.e., biopsy or resection) Note 2: 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.
2	Reason for Follow-Up Form Submission?	<input type="checkbox"/> Scheduled (Routine) Follow-up Submission <input type="checkbox"/> Additional New Tumor Event	3233305 Indicate the reason for submission of this follow-up form. Note: If scheduled follow-up, complete entire form. If additional new tumor event, complete only questions pertaining to new tumor.
3	Is This Patient Lost to Follow-up?	<input type="checkbox"/> Yes <input type="checkbox"/> No	61333 Indicate whether the patient is lost to follow-up as defined by the ACoS Commission on Cancer. This only includes cases where updated information has not been collected within the last 15 months. If the patient is lost to follow-up, the remaining questions may be left unanswered. Note: Note: 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.
4	Adjuvant Post-Operative Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2005312 Indicate whether the patient had adjuvant/ post-operative radiation therapy. Note: If the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.
5	Adjuvant Post-Operative Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2785850 Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy. Note: If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.
6	Measure of Success of Outcome at the Completion of Initial First Course Treatment (surgery and adjuvant therapies)	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Progressive Disease <input type="checkbox"/> Stable Disease <input type="checkbox"/> Partial Response <input type="checkbox"/> Complete Response <input type="checkbox"/> Unknown	2786727 Provide the patient's response to their initial first course treatment.
Patient Status			
7	Vital Status*	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	5 Indicate whether the patient was living or deceased at the date of last contact.

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Date of Last Contact (or date of death, if deceased)			
8	Month of Last Contact	<input type="text"/> <input type="text"/> (MM)	2897020 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). Note: Do not answer this question if the patient is deceased.
9	Day of Last Contact	<input type="text"/> <input type="text"/> (DD)	2897022 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). Note: Do not answer this question if the patient is deceased.
10	Year of Last Contact	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (YYYY)	2897024 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). Note: Do not answer this question if the patient is deceased.
11	Number of Days from Date of Initial Pathologic Diagnosis to Date of Last Contact	_____	3008273 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of Last Contact. Note: Do not answer this question if the patient is deceased. Note: 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.
Date of Death		<input type="checkbox"/> Not Applicable (Patient is Alive)	
12	Month of Death	<input type="text"/> <input type="text"/> (MM)	2897026 If the patient is deceased, provide the month of death.
13	Day of Death	<input type="text"/> <input type="text"/> (DD)	2897028 If the patient is deceased, provide the day of death.
14	Year of Death	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (YYYY)	2897030 If the patient is deceased, provide the year of death.
15	Number of Days from Date of Initial Pathologic Diagnosis to Date of Death	_____	3165475 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of Death. Note: 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.
16	Tumor Status (at date of last contact or at time of death)	<input type="checkbox"/> Tumor Free <input type="checkbox"/> With Tumor <input type="checkbox"/> Unknown Tumor Status	2759550 Indicate whether the patient was tumor/disease free from the tumor submitted for TCGA at the date of last contact or death.
17	Cause of Death	<input type="checkbox"/> Pancreatic Cancer <input type="checkbox"/> Surgical Complications <input type="checkbox"/> Other Malignancy (non-pancreatic cancer related) <input type="checkbox"/> Other Non-Malignant Disease <input type="checkbox"/> Other Cause of Death (i.e. accident related) <input type="checkbox"/> Unknown Cause of Death	2554674 If the patient is deceased, indicate the cause of death for the patient.
New Tumor Event: Please verify that the new tumor event information has not previously been reported on the Enrollment Form or on a prior Follow-up Form.			
18	New Tumor Event After Initial Treatment*	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3121376 Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after their initial treatment for the tumor submitted to TCGA. Note: If the patient had multiple new tumor events, a follow-up form should be completed for each new tumor event.

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Date of New Tumor Event After Initial Treatment <input type="checkbox"/> Not Applicable			
19	Month of New Tumor Event After Initial Treatment	<input type="text"/> <input type="text"/> (MM)	3104044 If the patient had a new tumor event, provide the month of diagnosis for this new tumor event.
20	Day of New Tumor Event After Initial Treatment	<input type="text"/> <input type="text"/> (DD)	3104042 If the patient had a new tumor event, provide the day of diagnosis for this new tumor event.
21	Year of New Tumor Event After Initial Treatment	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (YYYY)	3104046 If the patient had a new tumor event, provide the year of diagnosis for this new tumor event.
22	Number of Days from Date of Initial Pathologic Diagnosis to Date of New Tumor Event	_____	3392464 Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of new tumor event. Note: 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.
23	Type of New Tumor Event	<input type="checkbox"/> Locoregional Recurrence <input type="checkbox"/> Distant Metastasis <input type="checkbox"/> New Primary Tumor	3119721 Indicate whether the patient's new tumor event was a loco-regional recurrence or a distant metastasis of the tissue submitted for TCGA; or a new primary tumor. Note: If the patient had multiple new tumor events a follow-up form should be completed for each new tumor event.
24	Site of New Tumor Event	<input type="checkbox"/> Lung <input type="checkbox"/> Tumor Bed <input type="checkbox"/> Liver <input type="checkbox"/> Other <input type="checkbox"/> Peritoneal Surfaces <input type="checkbox"/> Non-Regional Lymph Nodes / Distant Lymph Nodes	3108271 Indicate the site of this new tumor event, as it relates to the tissue submitted for TCGA.
25	Other site of New Tumor Event (please specify)	_____	3128033 If the tumor site is not included in the list for the question above, designate the site of this new tumor event.
26	Diagnostic Evidence of Recurrence / Relapse (check all that apply)	<input type="checkbox"/> Biopsy w/Histologic Confirmation <input type="checkbox"/> Convincing Imaging <input type="checkbox"/> Positive Biomarker(s)	2786205 Indicate the procedure or testing method used to diagnose tumor recurrence or relapse.
27	Additional Surgery for New Tumor Event	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3008755 Using the patient's medical records, indicate whether the patient had surgery for the new tumor event in question.
Date of Additional Surgery for New Tumor Event <input type="checkbox"/> Not Applicable (No Additional Surgery for New Tumor Event)			
28	Month of Additional Surgery for New Tumor Event	<input type="text"/> <input type="text"/> (MM)	3427612 If the patient had surgery for the new tumor event provide the month this surgery was performed.
29	Day of Additional Surgery for New Tumor Event	<input type="text"/> <input type="text"/> (DD)	3427613 If the patient had surgery for the new tumor event provide the day this surgery was performed.
30	Year of Additional Surgery for New Tumor Event	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (YYYY)	3427614 If the patient had surgery for the new tumor event provide the year this surgery was performed.

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Question #	Data Element Label	Data Entry Alternatives	CDE ID With Working Instructions
31	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event	_____	3008335 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. Note: 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.
32	Residual Tumor after Surgery for New Tumor Event	<input type="checkbox"/> RX <input type="checkbox"/> R0 <input type="checkbox"/> R1 <input type="checkbox"/> R2 <input type="checkbox"/> Not Evaluated	3008753 If the patient had surgery for the new tumor event provide the status of any residual tumor after this surgery.
Additional Treatment			
33	Additional Treatment of New Tumor Event Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	3008761 Indicate whether the patient received radiation treatment for this new tumor event.
34	Additional Treatment of New Tumor Event Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	2650646 Indicate whether the patient received pharmaceutical treatment for this new tumor event.
35	Measure of Success of Outcome at the Completion of this Follow-up Submission	<input type="checkbox"/> Not Applicable <input type="checkbox"/> Partial Response <input type="checkbox"/> Progressive Disease <input type="checkbox"/> Complete Response <input type="checkbox"/> Stable Disease <input type="checkbox"/> Unknown	3104050 Provide the patient's outcome of treatment up to the point of the current follow-up data submission.

Comments:

Principal Investigator Name: _____

Principal Investigator Signature: _____

Date Signed (MM/DD/YYYY): _____