

Enrollment Form Thyroid (THCA)

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. 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.
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. 3088492
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. 3088528

Patient Information

4*	Date of Birth	<div> <div>_____</div> <div>_____</div> <div>_____</div> </div> <div> <div>Month</div> <div>Day</div> <div>Year</div> </div>	Provide the date the patient was born. 2896950 (Month), 2896952 (Day), 2896954 (Year)
5	Number of Days from Date of Initial Pathologic Diagnosis to Date of Birth	<div>_____</div>	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the patient's date of birth. 3008233 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.
6*	Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Provide the patient's gender using the defined categories. 2200604

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#	Data Element	Entry Alternatives	Working Instructions
7	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. 2192199
8	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. 2192217
9*	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. 3382736 If this question cannot be answered because the answer is unknown, the case will be excluded from TCGA. 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.
10*	History of Neo-adjuvant (Pre-Operative) Treatment for Tumor 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. 3382737 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.
11	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. 2759550
12*	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. 5
13	Date of Last Contact	<div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">Month</div> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">Day</div> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">Year</div> </div>	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) Do not answer if patient is deceased.

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#	Data Element	Entry Alternatives	Working Instructions
14	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. 3008273 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.
15	Date of Death	____ _ ____ _ ____ _ Month Day Year	If the patient is deceased, provide the date of death. 2897026 (Month), 2897028 (Day), 2897030 (Year)
16	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. 3165475 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.
17	Thyroid Medical History (Check all that apply)	<input type="checkbox"/> Normal <input type="checkbox"/> Lymphocytic Thyroiditis <input type="checkbox"/> Nodular Hyperplasia <input type="checkbox"/> Unknown <input type="checkbox"/> Other, please specify	Provide the patient's thyroid medical history. 3176743
18	Other Thyroid Medical History	_____	If the patient has had a history of thyroid related disease/disorder(s) and it is not included in the list provided, please describe the patient's thyroid health history. 3179397
19	History of Thyroid Cancer for First Degree Relatives (Check all that apply)	<input type="checkbox"/> Parent <input type="checkbox"/> Siblings <input type="checkbox"/> Children <input type="checkbox"/> Unknown	Provide any known family history of thyroid cancer for first degree relatives only. If the patient had no family history of thyroid cancer, skip this question. 3179002
20	History of Radiation Exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had a history of radiation exposure. 2816350

Pathologic/Prognostic Information

Pathologic Diagnosis Information

21*	Primary Site of Disease	<input type="checkbox"/> Thyroid	Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for TCGA. 2735776
22*	Histological Subtype	<input type="checkbox"/> Thyroid Papillary Carcinoma - Classical/usual <input type="checkbox"/> Thyroid Papillary Carcinoma - Follicular (≥ 99% follicular patterned) <input type="checkbox"/> Thyroid Papillary Carcinoma - Tall cell (≥ 50% tall cell features) <input type="checkbox"/> Other, specify below	Using the patient's pathology/laboratory report, select the histology and/or subtype of the tumor submitted for TCGA. 3081934
23	Other Histological Subtype	_____	If the histological subtype on the pathology/laboratory report does not fall under the provided histological types, describe the histology and/or subtype here. 3124492
24*	Tumor Laterality	<input type="checkbox"/> Left <input type="checkbox"/> Isthmus <input type="checkbox"/> Right <input type="checkbox"/> Total Thyroid <input type="checkbox"/> Bilateral <input type="checkbox"/> Thyroid NOS	Using the patient's pathology/laboratory report, indicate the laterality of the tumor. Include all areas of the tumor. 3186750
25*	Tumor Focality	<input type="checkbox"/> Unifocal <input type="checkbox"/> Multifocal	Using the patient's pathology/laboratory report, indicate the Focality of the tumor. Include all areas of the tumor. 3174022
26	Tumor Size	_____ (length) x _____ (width) x _____ (depth) cm	Using the patient's pathology/laboratory report, indicate the tumor size. Provide the greatest dimension, including all areas of the tumor. 2764966

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#	Data Element	Entry Alternatives	Working Instructions
27*	Date of Initial Pathologic Diagnosis	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">Month</div> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">Day</div> <div style="border-bottom: 1px solid black; width: 100px; text-align: center;">Year</div> </div>	Provide the date the patient was initially pathologically diagnosed with the malignancy submitted for TCGA. 2896956 (Month), 2896958 (Day), 2896960 (Year)
28	Age at Initial Diagnosis	<div style="border-bottom: 1px solid black; width: 200px; margin: 0 auto;"></div>	Provide the age of the patient in years, at the time the patient was initially pathologically diagnosed. 2006657 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.
Lymph Node Status			
29	Preoperative Imaging of Lymph Nodes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received preoperative imaging of the lymph nodes. 3178301
30	Type of Preoperative Imaging of Lymph Nodes (Check all that apply)	<input type="checkbox"/> Ultrasound <input type="checkbox"/> CT with contrast <input type="checkbox"/> CT without contrast <input type="checkbox"/> MRI with contrast <input type="checkbox"/> MRI without contrast <input type="checkbox"/> Unknown	If the patient received preoperative imaging of the lymph nodes, indicate what type of imaging was done. 3178310
31	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. 2200396
32	Number of Lymph Nodes Examined	<div style="border-bottom: 1px solid black; width: 150px; margin: 0 auto;"></div>	Provide the number of lymph nodes examined, if one or more lymph nodes were removed. 3
33	Number of Lymph Nodes Positive by H&E light microscopy	<div style="border-bottom: 1px solid black; width: 150px; margin: 0 auto;"></div>	Provide the number of lymph nodes positive through hematoxylin and eosin (H&E) staining and light microscopy. 3086388
34	Extrathyroidal Extension	<input type="checkbox"/> None <input type="checkbox"/> Minimal (T3) <input type="checkbox"/> Moderate/Advanced (T4a) <input type="checkbox"/> Very Advanced (T4b) <input type="checkbox"/> Unknown	Indicate whether there was extrathyroidal extension. If there was extrathyroidal extension, provide the type. 3179452
35	Residual Tumor	<input type="checkbox"/> RX <input type="checkbox"/> R0 <input type="checkbox"/> R1 (microscopic residual disease) <input type="checkbox"/> R2 (gross residual disease) <input type="checkbox"/> Unknown	Using the patient's operative report, indicate whether there was residual tumor after the surgical procedure. 2608702
AJCC Staging			
36*	AJCC Cancer Staging Edition	<input type="checkbox"/> 1 st Edition (1978-1983) <input type="checkbox"/> 2 nd Edition (1984-1988) <input type="checkbox"/> 3 rd Edition (1989-1992) <input type="checkbox"/> 4 th Edition (1993-1997) <input type="checkbox"/> 5 th Edition (1998-2002) <input type="checkbox"/> 6 th Edition (2003-2009) <input type="checkbox"/> 7 th Edition (2010-present)	Please select the AJCC Cancer Staging Edition used to answer the following questions. 2722309
37*	Pathologic T Stage	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> TX <input type="checkbox"/> T0 <input type="checkbox"/> Tis <input type="checkbox"/> T1 </div> <div style="width: 50%;"> <input type="checkbox"/> T1a <input type="checkbox"/> T1b <input type="checkbox"/> T1c <input type="checkbox"/> T2 </div> <div style="width: 50%;"> <input type="checkbox"/> T2a <input type="checkbox"/> T2b <input type="checkbox"/> T3 <input type="checkbox"/> T3a </div> <div style="width: 50%;"> <input type="checkbox"/> T3b <input type="checkbox"/> T4 <input type="checkbox"/> T4a <input type="checkbox"/> T4b </div> </div>	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). 3045435
38*	Pathologic N Stage	<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <input type="checkbox"/> NX <input type="checkbox"/> N0 <input type="checkbox"/> N1 </div> <div style="width: 50%;"> <input type="checkbox"/> N1a <input type="checkbox"/> N1b <input type="checkbox"/> N1c <input type="checkbox"/> N2 </div> </div>	Using the patient's pathology/laboratory report, select the code for the pathologic N (nodal) defined by the American Joint Committee on Cancer (AJCC). 3203106
39*	Pathologic M Stage	<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). 3045439

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40*	Stage	<input type="checkbox"/> Stage I <input type="checkbox"/> Stage IVA <input type="checkbox"/> Stage II <input type="checkbox"/> Stage IVB <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IVC <input type="checkbox"/> Stage IV	Using the patient's pathology/laboratory report, select the stage defined by the American Joint Committee on Cancer (AJCC). 3203222																
Metastatic Tumor <i>(Complete when applicable)</i>																			
41	If patient had metastatic disease, how was it confirmed? <i>(Check all that apply)</i>	<input type="checkbox"/> RAI-avid <input type="checkbox"/> Biopsy Proven <input type="checkbox"/> Imaging Suspected <input type="checkbox"/> Unknown <input type="checkbox"/> Other, please specify	If the patient had a metastatic tumor, provide the method used to confirm the metastatic diagnosis. If the patient did not have a metastatic tumor, skip this and the following metastatic questions. 3178364																
42	Metastatic Diagnosis Confirmed by Other	_____	If the patient had a metastatic tumor and the method used to confirm the diagnosis is not included in the provided list, please describe the method. 3178376																
43	If patient had metastatic disease, provide the site. <i>(Check all that apply)</i>	<input type="checkbox"/> Lung <input type="checkbox"/> Bone <input type="checkbox"/> Unknown <input type="checkbox"/> Other, please specify	If the patient had a metastatic tumor associated with the 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. 2967298																
44	Other Site of Metastatic Tumor	_____	If the site of the metastasis was not included in the list provided, please provide the site. 3178387																
Genotypic Analysis																			
45	Genotypic Analysis Detected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether genotypic analysis was detected for the patient. 3179001																
46	Reason(s) for Genotypic Analysis not Detected	<table border="1"> <thead> <tr> <th></th><th>No Mutation</th><th>Not Performed</th><th>Unknown</th></tr> </thead> <tbody> <tr> <td>BRAF Mutation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>RAS Mutation</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr> <td>RET/PTC Rearrangement</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table>		No Mutation	Not Performed	Unknown	BRAF Mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RAS Mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RET/PTC Rearrangement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If genotypic analysis was NOT detected, indicate why for each mutation/rearrangement. 3179383
	No Mutation	Not Performed	Unknown																
BRAF Mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
RAS Mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
RET/PTC Rearrangement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																
47	BRAF Mutation Result	_____	Based on genotypic analysis performed, provide the BRAF mutation results for this patient. If the patient's results are unknown or if genotypic analysis was not performed, skip this question. 3179257																
48	RAS Mutation Result	_____	Based on genotypic analysis performed, provide the RAS mutation results for this patient. If the patient's results are unknown or if genotypic analysis was not performed, skip this question. 3179266																
49	RET/PTC Rearrangement Result	_____	Based on genotypic analysis performed, provide the RET/PTC rearrangement mutation results for this patient. If the patient's results are unknown or if genotypic analysis was not performed, skip this question. 3179271																
50	Other Genotypic Analysis Results	_____	Based on genotypic analysis performed, provide any other mutation results for this patient. If the patient's results are unknown or if genotypic analysis was not performed, skip this question. 3179278																
Treatment Information																			
51*	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. 2005312 If the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.																

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#	Data Element	Entry Alternatives	Working Instructions
52*	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. 3397567 <i>If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.</i>
Adjuvant I-131 Therapy and Radiation Therapy (XRT) For Primary Tumor			
53	I-131 Treatment: Method of preparation	<input type="checkbox"/> rhTSH <input type="checkbox"/> Thyroxine withdrawal <input type="checkbox"/> Patient did not receive I-131 treatment <input type="checkbox"/> Unknown	If the patient received I-131 therapy for the primary tumor, indicate the method used. 3232952 <i>If the patient did NOT receive I-131 therapy for the primary tumor, related questions can be skipped.</i>
54	I-131 Treatment: Dose of First Treatment	_____	If the patient received I-131 therapy for the primary tumor, provide the dose of the first treatment. 3232898
55	I-131 Treatment: Subsequent Treatments	_____	If the patient received I-131 therapy for the primary tumor, detail subsequent treatments. 3232904
56	I-131 Treatment: Total Cumulative Dose	_____	If the patient received I-131 therapy for the primary tumor, provide the total cumulative dose. 3232906
57	Radiation Therapy (XRT): Method of preparation	<input type="checkbox"/> Hyperfractionated <input type="checkbox"/> IMRT <input type="checkbox"/> Patient did not receive external radiation therapy <input type="checkbox"/> Unknown	If the patient received radiation therapy for the primary tumor, indicate the method of preparation. 3232960
58	Radiation Therapy (XRT): Dose Administered	_____	If the patient received radiation therapy for the primary tumor, provide the dose administered. 3232933
59	Radiation Therapy (XRT): Radiation Sensitizers Administered	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If the patient received radiation therapy for the primary tumor, indicate whether or not radiation sensitizers were administered. 3232932
Clinical Status after Surgery			
60	Clinical Status Within Three (3) Months of Surgery	<input type="checkbox"/> No Imaging Evidence of Disease <input type="checkbox"/> Persistent Locoregional Disease <input type="checkbox"/> Persistent Distant Metastases <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	Indicate the patient's clinical status within three months of the surgery related to thyroid carcinoma submitted for TCGA. 3186684
New Tumor Event Information <i>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.</i>			
61	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 initial treatment. 3121376 <i>If the patient did not have a new tumor event or if this is unknown, the remaining questions can be skipped.</i>
62	Type of New Tumor Event	<input type="checkbox"/> Locoregional <input type="checkbox"/> Distant Metastasis <input type="checkbox"/> New Primary Tumor <input type="checkbox"/> Biochemical Evidence of Disease	Indicate whether the patient's new tumor event was a locoregional recurrence, a distant metastasis or a new primary tumor. A new primary tumor is a tumor with a different histology as the tumor submitted to TCGA. 3119721
63	Site of New Tumor Event	<input type="checkbox"/> Lung <input type="checkbox"/> Bone <input type="checkbox"/> Soft Tissue <input type="checkbox"/> Lymph Node(s) <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	Indicate the site of this new tumor event. 3108271
64	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

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#	Data Element	Entry Alternatives	Working Instructions
65	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)
66	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. 3392464 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.
67	New Tumor Event Diagnosis Confirmed By	<input type="checkbox"/> Imaging <input type="checkbox"/> Pathology <input type="checkbox"/> Unknown	If the patient had a new tumor event, provide the method used to confirm this diagnosis. 3186701
68	Evidence of Histologic Progression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the new tumor event had evidence of histologic progression. 3181376
69	Type of Histologic Progression	<input type="checkbox"/> Poorly Differentiated <input type="checkbox"/> Anaplastic <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	If the new tumor event had evidence of histologic progression, indicate the type of evidence. 3181384
70	Other Type of Histologic Progression	_____	If the histologic progression for the new tumor event is not included in the list provided, describe the type of progression. 3181387
71	If lymph nodes are positive, specify site(s) <i>Check all that apply</i>	<input type="checkbox"/> Central (levels 6-7) <input type="checkbox"/> Lateral (levels 2-5) <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	If the patient had positive lymph nodes, provide the site of the positive nodes. 3186207
72	Other Site of Positive Lymph Nodes	_____	If the patient had positive lymph nodes and the site is not included in the provided list, please indicate the location. 3185693
73	Additional Therapy Required for New Tumor Event <i>Check all that apply</i>	<input type="checkbox"/> No Additional Therapy <input type="checkbox"/> Surgery <input type="checkbox"/> RAI Therapy <input type="checkbox"/> EBRT <input type="checkbox"/> Pharmaceutical Therapy <input type="checkbox"/> Unknown	Indicate the type of additional therapy required for the new tumor event. 3185186
74	Additional treatment for New Tumor Event: <i>Surgery</i>	<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. 3427611
75	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)
78	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. 3008335 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.

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79	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. 3427615
80	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. 3427616
Adjuvant I-131 Therapy and Radiation Therapy (XRT) For New Tumor Event			
81	I-131 Treatment: Method of preparation	<input type="checkbox"/> rhTSH <input type="checkbox"/> Thyroxine withdrawal <input type="checkbox"/> Patient did not receive I-131 treatment <input type="checkbox"/> Unknown	If the patient received I-131 therapy for the new tumor event, indicate the method used. 3232952 NOTE: If the patient did NOT receive I-131 therapy for the new tumor event, related questions can be skipped.
82	I-131 Treatment: Dose of First Treatment	_____	If the patient received I-131 therapy for the new tumor event, provide the dose of the first treatment. 3232898
83	I-131 Treatment: Subsequent Treatments	_____	If the patient received I-131 therapy for the new tumor event, detail subsequent treatments. 3232904
84	I-131 Treatment: Total Cumulative Dose	_____	If the patient received I-131 therapy for the new tumor event, provide the total cumulative dose. 3232906
85	Radiation Therapy (XRT): Method of preparation	<input type="checkbox"/> Hyperfractionated <input type="checkbox"/> IMRT <input type="checkbox"/> Patient did not receive external radiation therapy <input type="checkbox"/> Unknown	If the patient received radiation therapy for the new tumor event, indicate the method of preparation. 3232960
86	Radiation Therapy (XRT): Dose Administered	_____	If the patient received radiation therapy for the new tumor event, provide the dose administered. 3232933
87	Radiation Therapy (XRT): Radiation Sensitizers Administered	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If the patient received radiation therapy for the new tumor event, indicate whether or not radiation sensitizers were administered. 3232932

 Principal Investigator or Designee Signature

 Print Name

 ____/____/_____
 Date