

Follow-Up Form Thyroid (THCA)

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	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	Please note that the time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box. 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 Patient Lost to Follow-up?	<input type="checkbox"/> Yes <input type="checkbox"/> 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
3	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.
4	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 If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.
5	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
6	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

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#	Data Element	Entry Alternatives	Working Instructions
7	Month of Last Contact	<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 is living, provide the month of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver). 2897020 Do not answer if patient is deceased.
8	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	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). 2897022 Do not answer if patient is deceased.
9	Year of Last Contact	_____	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). 2897024 Do not answer if patient is deceased.
10	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.
11	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	If the patient is deceased, provide the month of death. 2897026
12	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	If the patient is deceased, provide the day of death. 2897028
13	Year of Death	_____	If the patient is deceased, provide the year of death. 2897030
14	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.

Treatment Information

#	Data Element	Entry Alternatives	Working Instructions
Adjuvant I-131 Therapy and Radiation Therapy (XRT) For Primary Tumor			
15	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 NOTE: If the patient did NOT receive I-131 therapy for the primary tumor, related questions can be skipped.
16	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
17	I-131 Treatment: Subsequent Treatments	_____	If the patient received I-131 therapy for the primary tumor, detail subsequent treatments. 3232904
18	I-131 Treatment: Total Cumulative Dose	_____	If the patient received I-131 therapy for the primary tumor, provide the total cumulative dose. 3232906

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#	Data Element	Entry Alternatives	Working Instructions
19	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
20	Radiation Therapy (XRT): Dose Administered	_____	If the patient received radiation therapy for the primary tumor, provide the dose administered. 3232933
21	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			
22	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 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
23	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 If the patient did not have a new tumor event or if this is unknown, the remaining questions can be skipped.
24	Type of New Tumor Event	<input type="checkbox"/> Locoregional Recurrence <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
25	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
26	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
27	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. 3104044
28	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. 3104042
29	Year of New Tumor Event	_____	If the patient had a new tumor event, provide the year of diagnosis for this new tumor event. 3104046
30	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.

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#	Data Element	Entry Alternatives	Working Instructions
<u>31</u>	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
<u>32</u>	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
<u>33</u>	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
<u>34</u>	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
<u>35</u>	If lymph nodes are positive, specify site(s).	<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
<u>36</u>	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
<u>37</u>	Additional Therapy Required for New Tumor Event <i>Check all that apply</i>	<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
<u>38</u>	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
<u>39</u>	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. 3427612
<u>40</u>	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. 3427613
<u>41</u>	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. 3427614
<u>42</u>	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 (loco-regional). 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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#	Data Element	Entry Alternatives	Working Instructions
<u>43</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. 3427615
<u>44</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. 3427616
Adjuvant I-131 Therapy and Radiation Therapy (XRT) For New Tumor Event			
<u>45</u>	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.
<u>46</u>	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
<u>47</u>	I-131 Treatment: Subsequent Treatments	_____	If the patient received I-131 therapy for the new tumor event, detail subsequent treatments. 3232904
<u>48</u>	I-131 Treatment: Total Cumulative Dose	_____	If the patient received I-131 therapy for the new tumor event, provide the total cumulative dose. 3232906
<u>49</u>	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
<u>50</u>	Radiation Therapy (XRT): Dose Administered	_____	If the patient received radiation therapy for the new tumor event, provide the dose administered. 3232933
<u>51</u>	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