Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

OTHER CANCER FORM (OCF/OCQ)
CONFIRMATION OF CANCERS OTHER THAN PLCO

1. Date Abstracted: ____________________________
   Month   Day   Year

2. Satellite Center: ___ ___

3. Abstractor ID#: ___ ___ ___ ___

4. Study Year: ___ ___

5. Purpose of Abstract:
   ○ Initial abstract
   ○ Re-abstract for QA

PART A: CONFIRMATION OF CANCER

6. Result of Confirmation of Reported Non-PLCO Cancer (MARK ONLY ONE):
   ○ Primary Non-PLCO Cancer (GO TO ITEM A.7)
   ○ Metastatic Site – Unknown Primary (GO TO ITEM A.7)
   ○ Metastatic Site – PLCO Primary (GO TO ITEM A.6a)

6a. Type of PLCO Cancer (MARK ONLY ONE):
   ○ Prostate
   ○ Lung
   ○ Colorectum
   ○ Ovary
   (GO TO ITEM A.12)

7. Date of Cancer Diagnosis: ____________________________
   Month   Day   Year

8. ICD-O-2 Cancer Classification of Primary Cancer:

   CTR ID#: ___ ___ ___ ___
   _____-_____-_____-_____ (Topography) (Morphology) (Behavior) (Grade)
9. Verbatim Description of Cancer Diagnosis:
   ____________________________________________
   ____________________________________________
   ____________________________________________

10. Basis of Diagnosis: (MARK ONLY ONE)
    ○ Histology
    ○ Cytology
    ○ Radiology
    ○ Other (SPECIFY): _______________________________

11. Photocopy of Report Confirming Cancer Attached?
    ○ No
    ○ Yes

12. Reported Metastatic Sites:
    ○ None Reported (GO TO PART B)

    Record Up to Three Sites:
    Site: _______________________________
    Site: _______________________________
    Site: _______________________________

PART B: PHYSICIAN/HOSPITAL LOCATION INFORMATION

13. Physician for Primary or Metastatic Cancer Diagnosis Information:

   a. Name: _________________________________________________________________________________
      Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Chart # ______________________

   b. Name: _________________________________________________________________________________
      Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Chart # ______________________
14. Hospital or Clinic for Primary or Metastatic Cancer Diagnosis Information:

a. Name: ________________________________________________________________

   Address: ________________________________________________________________
   City       State   ZIP Code

   Telephone: (___) _________________________   Chart # ______________________

b. Name: ________________________________________________________________

   Address: ________________________________________________________________
   City       State   ZIP Code

   Telephone: (___) _________________________   Chart # ______________________

15. Comments:

   ○ No
   ○ Yes (SPECIFY)

   Item # | Comments
   --------|------------------
   (CONTINUED)

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Form Processing (DARKEN CIRCLES AS STEPS ARE COMPLETED)

   ○ Form Receipted into SMS
   ○ Manual Review Completed

Data Retrieval:

   ○ Attempted OR
   ○ None Required

Data Entry of Non-Scannable Items:

   ○ Completed OR
   ○ None Required

Final Disposition:

   ○ Interim Complete (ICM)
   ○ Final Complete (FCM)
   ○ Final Incomplete (FIC)