**Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial**

**MEDICAL RECORD ABSTRACT FORM**
**TREATMENT INFORMATION - LUNG (TIL2/TLQ2)**

1. **Date Abstracted:**
   - MO. DAY YEAR
   - 20

2. **Abstractor ID #:**
   - 0 0 0 0 0

3. **CTR ID #:**
   - 0 0 0 0 0

4. **Study Year T0-T13:**
   - T

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

---

**FOR OFFICE USE ONLY**

**Form Processing (Mark responses as steps are completed)**

6. **Data Entry of Non-Scannable Items:**
   - Completed
   - None Required

7. **Data Retrieval:**
   - Attempted
   - None Required

**Disposition:**

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

---

**PART A: INITIAL TREATMENT INFORMATION**

1. **RADIATION TREATMENT FOR LUNG CANCER:**
   - No
   - Yes (COMPLETE TABLE BELOW)
   - Unknown

**TREATMENT #**

<table>
<thead>
<tr>
<th>TREATMENT #</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
</table>

**DATE RADIATION TREATMENT BEGAN**

(MO. - DAY - YEAR)

<table>
<thead>
<tr>
<th>MO.</th>
<th>DAY</th>
<th>YEAR</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

---

**PLEASE DO NOT WRITE IN THIS AREA**

008811
### Part A Continued...

#### 2. Surgical Treatment for Lung Cancer:

<table>
<thead>
<tr>
<th>Procedure #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type of Surgical Procedure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(See Surgical Procedure Codes Below, if other, specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Date of Surgery</strong></td>
<td>MO.</td>
<td>DAY</td>
<td>YEAR</td>
<td>MO.</td>
</tr>
<tr>
<td>(MO. - DAY - YEAR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Surgical Procedure Codes**

- 01 = Exploratory thoracotomy without resection
- 02 = Median sternotomy
- 04 = Lobectomy
- 06 = Bilobectomy
- 08 = Pneumonectomy
- 11 = Wedge resection
- 12 = Segmental resection
- 13 = Lymphadenectomy/Lymph node sampling
- 14 = Chest wall resection
- 15 = Thoracentesis
- 16 = Partial pleurectomy
- 88 = Other (Specify)

#### 3. Chemotherapeutic Treatment for Lung Cancer:

<table>
<thead>
<tr>
<th>Treatment #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Chemotherapeutic Treatment Began</strong></td>
<td>MO.</td>
<td>DAY</td>
<td>YEAR</td>
<td>MO.</td>
</tr>
<tr>
<td>(MO. - DAY - YEAR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---
4. OTHER TYPE OF TREATMENT FOR LUNG CANCER:
- No
- Yes (COMPLETE TABLE BELOW)
- Unknown

<table>
<thead>
<tr>
<th>TREATMENT #</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE OTHER TREATMENT BEGAN</td>
<td>MO.</td>
<td>DAY</td>
</tr>
<tr>
<td>(MO. - DAY - YEAR)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

5. ANY LOCAL OR REGIONAL RESIDUAL DISEASE LEFT AFTER SURGERY:
- No
- Yes - Microscopic
- Yes - Gross Tumor
- Not applicable
- Unknown

6. PHYSICIAN/HOSPITAL LOCATION INFORMATION

6a. Name: ____________________________
Address: ____________________________
Telephone: ____________________________
City: ____________________________ State: ____________________________ ZIP Code: ____________________________
Medical Record/Chart #: ____________________________

6b. Name: ____________________________
Address: ____________________________
Telephone: ____________________________
City: ____________________________ State: ____________________________ ZIP Code: ____________________________
Medical Record/Chart #: ____________________________

7. HOSPITAL OR CLINIC FOR TREATMENT:

7a. Name: ____________________________
Address: ____________________________
Telephone: ____________________________
City: ____________________________ State: ____________________________ ZIP Code: ____________________________
Medical Record/Chart #: ____________________________

7b. Name: ____________________________
Address: ____________________________
Telephone: ____________________________
City: ____________________________ State: ____________________________ ZIP Code: ____________________________
Medical Record/Chart #: ____________________________
8. COMMENTS:

<table>
<thead>
<tr>
<th>Item #</th>
<th>Comments</th>
</tr>
</thead>
</table>

☐ No  ☐ Yes (SPECIFY)

( CONTINUED)