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

1. Date Abstracted: ____________________________
   Month   Day   Year

2. Abstractor ID#: ___ ___ ___ ___

3. CTR ID: ___ ___ ___ ___

4. Study Year T0-T13: ___ ___

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

FOR OFFICE USE ONLY

6. Form Processing (MARK RESPONSES AS STEPS ARE COMPLETED)
   ○ Form Receipted into SMS
   ○ Manual Review Completed

   Data Entry of Non-Scannable Items:
   ○ Completed
   ○ None Required

   Data Retrieval:
   ○ Attempted
   ○ None Required

   Disposition:
   ○ Interim Complete (ICM)
   ○ Final Complete (FCM)
   ○ Final Incomplete (FIC)
1. RADIATION 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 RADIATION TREATMENT BEGAN (MO.-DAY-YEAR)</td>
<td></td>
<td></td>
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</tbody>
</table>

2. SURGICAL TREATMENT FOR LUNG CANCER:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)
   ○ Unknown

<table>
<thead>
<tr>
<th>PROCEDURE #</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>TYPE OF SURGICAL PROCEDURE (SEE SURGICAL PROCEDURE CODES BELOW. IF OTHER, SPECIFY)</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
<td>SPECIFY</td>
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<tr>
<td>DATE OF SURGERY (MO.-DAY-YEAR)</td>
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SURGICAL PROCEDURE CODES
01 = Exploratory thoracotomy without resection
02 = Mediansternotomy
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:
   ○ No
   ○ Yes (COMPLETE TABLE BELOW)
   ○ Unknown

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

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

PART B: PHYSICIAN/HOSPITAL LOCATION INFORMATION

6. PHYSICIAN FOR TREATMENT:
   a. Name: _________________________________________________________________________________
      Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________
   b. Name: _________________________________________________________________________________
      Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________
7. HOSPITAL OR CLINIC FOR TREATMENT:
   a. Name: _________________________________________________________________________________
      Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________

   b. Name: _________________________________________________________________________________
      Address: _______________________________________________________________________________
      City       State   ZIP Code
      Telephone: (___) _________________________   Medical Record/Chart # ______________________

8. COMMENTS:
   ○ No
   ○ Yes (SPECIFY)

   Item # | Comments
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   ○ (CONTINUED)