[0938-0968 Form #8]

Initial Staging Form **Post-Scan**
National Oncologic PET Registry **F^{18} Fluoride PET Scan**

PET FACILITY ID #: _____

REGISTRY CASE #: _____

PATIENT NAME:_____

Your patient had a PET scan on *mm/dd/yyyy*. **[Date will automatically be filled.]**

You previously indicated that the PET scan was done for ***initial staging of*** *cancer type* **[Cancer type will automatically be filled in from data supplied on Pre-PET form.]**

After reviewing the PET report, please complete the following questions and return the form to the PET Facility.
This form must be entered into the database within 30 days of the PET scan.

1. COMPARED TO YOUR PRE-PET ASSESSMENT, WHAT IS YOUR IMPRESSION OF THE EXTENT OF THE PATIENT'S CANCER?

- ☐ **More extensive**
- ☐ **No change**
- ☐ **Less extensive**

2. DID THE PET SCAN ENABLE YOUR PATIENT TO AVOID ANY

a. noninvasive diagnostic tests?

- ☐ **Yes**
- ☐ **No**

b. any invasive procedures?

- ☐ **Yes**
- ☐ **No**

3. YOUR POST-PET WORKING CLINICAL SUMMARY STAGING IS? *(You must check only one)*

- ☐ **No evidence of disease / In remission**
- ☐ **Localized only**

- ☐ **Regional by direct extension**
- ☐ **Metastatic (distant) with a single suspected site**
- ☐ **Metastatic (distant) with multiple suspected sites**
- ☐ **Unknown or uncertain**

4. IN LIGHT OF THE PET FINDINGS, WHICH ONE OF THE FOLLOWING ARE YOU PLANNING OR HAVE YOU ALREADY DONE AS THE NEXT STEP IN YOUR CURRENT MANAGEMENT STRATEGY? *(check only one)*

- ☐ **Observation (with close follow-up)**

- ☐ **Additional Imaging (CT, MRI, FDG-PET)**

  [Note: Do not check this option if you would order a conventional bone scan if the F-18 fluoride PET bone scan were not available.]

- ☐ **Tissue Biopsy (surgical, percutaneous, or endoscopic).**

  [Note: If concurrent biopsy and a surgical procedure are planned, then mark "treatment" below.]

- ☐ **Supportive care only (e.g., pain management, hospice care)**

- ☐ **Treatment for the Cancer**

If treatment was selected, answer the questions below:

a. Treatment Goal: *(check one)*

- ☐ **Curative**
- ☐ **Palliative**

b. Treatment will be directed to: *(check all that apply)*

- ☐ **Primary tumor and/or locoregional disease**
- ☐ **Non-osseous distant metastatic disease**
- ☐ **Osseous distant metastatic disease**

c. Type(s): *(check all that apply)*

- ☐ **Surgery**
- ☐ **Radiation**
- ☐ **Chemotherapy (including biologic modifiers)**
- ☐ **Hormonal therapy**
- ☐ **Bisphosphonate therapy**
- ☐ **Immunotherapy (e.g., sipuleucel T (Provenge®) for prostate cancer)**
- ☐ **Radiopharmaceutical therapy (strontium-89, samarium-153, etc.)**
- ☐ **Other**

Specify other treatment type:_____

5. I HAVE READ THE INTERPRETING PHYSICIAN INFORMATION STATEMENT AND:

- ☐ **I DO give my consent for the inclusion of data collected for this patient in NOPR research.**
- ☐ **I DO NOT give my consent for the inclusion of data collected for this patient in NOPR research.**

6. NAME OF PERSON SUBMITTING THIS FORM

First Name: _____ Last Name:_____ Date: ____/____/____

7. PHYSICIAN ATTESTATION OF DATA ACCURACY

By signing below I verify that, to the best of my knowledge, the information on this form is accurate.

Physician Signature: _____ Date:

Printed Name of Physician: _____

Thank you for your assistance.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0968. The time required to complete this information collection is estimated to average five (5) minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.