

[0938-0968 Form #10]

Restaging Form Post-Scan
National Oncologic PET Registry

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 *restaging of cancer type* [Will automatically be filled in from data supplied on Pre-PET form.] to assess for

- new osseous metastatic disease as a site of recurrence or
- progression of known osseous metastatic disease.

[Reason 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. YOUR POST-PET WORKING CLINICAL STAGING IS: (SELECT ONLY ONE)

- No evidence of disease / In remission
- Low probability of local recurrence or metastases
- Local recurrence
- Metastatic (distant) with a single suspected site
- Metastatic (distant) with a multiple suspected sites

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

a. noninvasive diagnostic tests?

- Yes
- No

a. any invasive procedures?

- Yes
- No

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: _____

d. **Will treatment be directly provided by you?** *(check one)*

Yes

No

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

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