**[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
1. 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
1. DID THE PET SCAN ENABLE YOUR PATIENT TO AVOID ANY
2. noninvasive diagnostic tests?
* Yes
* No
1. any invasive procedures?
* Yes
* No
1. 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:
	1. Treatment Goal: (check one)
* Curative
* Palliative
	1. Treatment will be directed to: (check all that apply)
* Primary tumor and/or locoregional disease
* Non-osseous distant metastatic disease
* Osseous distant metastatic disease
	1. 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:

* 1. Will treatment be directly provided by you? (check one)
* ❑ Yes
* ❑ No
1. 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.
1. NAME OF PERSON SUBMITTING THIS FORM

First Name: Last Name: Date:

1. **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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