[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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