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**

- **If additional imaging is selected, please indicate which specific type of imaging you would order next.** *(check one)*
- ❑ Plain radiographs
- ❑ Body CT (neck, chest, and/or abdomen/pelvis)
- ❑ Extremity CT
- ❑ Body MRI (spine, neck, chest, and/or abdomen/pelvis)
- ❑ Extremity MRI
- ❑ FDG-PET
- ❑ Other, specify: _____

☐ **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 REFERRING 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.