

Case Registration and Pre-PET Form

Please fax this form and the order to Central Scheduling at 718-9270
within 48 hours of your initial request to schedule a PET exam.

Data from this form will be entered into the NOPR database via web by Central Scheduling.

PATIENT INFORMATION

First Name <i>(Please print legibly)</i>	
Last Name <i>(Please print legibly)</i>	
Date of Birth (MM/DD/YY)	
Social Security Number	

Gender *(You must check one)* Male Female
 Ethnicity *(You must check one)* Hispanic not Hispanic Unknown
 Race *(You must check one)* Asian Black or African American White or Caucasian
 Other Unknown

Patient's 5-digit Zip Code (If out US, enter 00000)					
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REFERRING PHYSICIAN INFORMATION

UPIN Number	
First Name <i>(Please print legibly)</i>	
Last Name <i>(Please print legibly)</i>	

PET EXAM DATE

Patient tentatively scheduled to have pet scan on (MM/DD/YY)	
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PATIENT INFORMATIONAL SHEET

Patient has been provided NOPR Patient Informational Sheet? *(Check one)* Yes No

DATE AND NAME OF PERSON SUBMITTING THIS FORM

Date of Submission	
First Name <i>(Please print legibly)</i>	
Last Name <i>(Please print legibly)</i>	
E-mail address	
Telephone Number	
Fax Number	

<i>For Central Scheduling Use Only</i>	
Registry Case Number assigned by ACRIN	

1. SPECIFIC REASON FOR PET STUDY

Check the single best match for the reason for the PET. (You must check only one of the following and then answer the section(s) indicated for Question 2.)

Diagnosis: To determine if a suspicious lesion is cancer (Answer 2a and 2b)

Diagnosis/Unknown Primary Tumor: To detect a primary tumor site in a patient with a confirmed metastatic lesion (Answer 2c)

Diagnosis/Paraneoplastic: To detect a primary tumor site in a patient with a presumed paraneoplastic syndrome (Answer 2a and 2b)

Initial Staging of histologically confirmed, newly diagnosed cancer (Answer 2a and 2b)

Monitoring Treatment Response during chemotherapy (Answer 2a and 2b)

Monitoring Treatment Response during radiation therapy (Answer 2a and 2b)

Monitoring Treatment Response during combined modality therapy (e.g., chemo ± radiation ± surgery ± biologic therapy) (Answer 2a and 2b)

Restaging after completion of therapy (Answer 2a and 2b)

Suspected Recurrence of a previously treated cancer (Answer 2a and 2b)

2. CANCER TYPE AND WORKING STAGE

For a patient with a known primary or clinically suspected cancer, please mark the corresponding box of the cancer type in Section 2a and answer Question 2b. For a patient with metastatic disease of unknown primary origin, mark the corresponding box of the site of the metastatic disease in Section 2c. If your patient's cancer is not listed, check the *Other* box and enter as text the cancer type.

a. Cancer Type (ICD-9 Code): Check the one cancer that most closely relates to the specific reason for the PET study indicated in response to Question 1. (You must check only one.)

Lip, Oral Cavity, and Pharynx (140-149)

Esophagus (150)

Stomach (151)

Small Intestine (152)

Colon (153) and Rectum (154)

Anus (154)

Liver and intrahepatic bile ducts (155)

Gallbladder and extrahepatic bile ducts (156)

Pancreas (157)

Retroperitoneum and peritoneum (158)

Nasal cavity, ear, and sinuses (160)

Larynx (161)

Lung, non-small cell (162)

Lung, small cell (162)

Pleura (163)

Thymus, heart, mediastinum (164)

Bone/cartilage (170)

Connective/other soft tissue (171)

Leukemia (204-208)

Other or not listed. (Please describe cancer type. Please write legibly.)

Melanoma of skin (172)

Female breast (174)

Male breast (175)

Kaposi's sarcoma (176)

Uterus, unspecified (173)

Cervix (180)

Uterus, body (182)

Ovary and uterine adnexa (183)

Prostate (185)

Testis (186)

Penis and other male genitalia (187)

Bladder (188)

Kidney and other urinary tract (189)

Eye (190)

Primary Brain (191)

Thyroid (193)

Lymphoma (200-202)

Myeloma (203)

b. Has this cancer diagnosis been pathologically proven? (*Check one*) Yes No

c. Unknown primary: site of pathologically proven metastatic disease (196-199)

Lymph node(s)	Brain
Lung	Bone/bone marrow
Liver	
Other (<i>Please specify. Please write legibly.</i>)	

3. YOUR WORKING SUMMARY STAGE FOR THE PATIENT BEFORE THE PET SCAN IS? (*You must check only one.*)

- No evidence of disease / In remission
- Localized only
- Regional by direct extension or lymph node involvement or both
- Metastatic (distant) with a single suspected site
- Metastatic (distant) with multiple suspected sites
- Unknown or uncertain

4. PATIENT PERFORMANCE STATUS

Check the box best describing your patient's global functional status (ECOG Performance Score). (*You must check only one.*)

- (0) Asymptomatic: *fully active, able to carry on all activities without restriction.*
- (1) Symptomatic, fully ambulatory: *restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature.*
- (2) Symptomatic in bed < 50% of the day: *ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours.*
- (3) Symptomatic in bed > 50% of the day but not bedridden: *capable of only limited self-care, confined to bed or chair 50% or more of waking hours.*
- (4) Bedridden: *Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.*

5. MANGEMENT PLAN

If PET were not available, your current management strategy would be: (*You must check only one.*)

Observation (with close follow-up)

Additional Imaging (CT, MRI) or other non-invasive diagnostic tests

Tissue Biopsy (surgical percutaneous, or endoscopic)

Note: If current biopsy and total surgical resection are planned, then mark "Surgical" treatment below.

Treatment (*If "Treatment" is selected, then also complete the following*)

Treatment Goal (<i>Check one</i>)	Curative	Palliative
Type(s) (<i>Check all that apply</i>)	Surgical	Chemo (including biologic modifiers)
	Radiation	Other
	Supportive care	

Will treatment be directly provided by you? (*Check one*) Yes No

THANK YOU FOR YOUR ASSISTANCE!