International CPT-SIOP-Registry – Follow-Up Form A2

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In Cooperation with the German Childhood Cancer Registry (GCCR), at IMBEI, Universitätsmedizin Mainz, 55101 Mainz (for patients registered in Germany)
Tel.: (+49) 6131 /17-6808 , Fax: (+49) 6131 / 17-4462, url: www.kinderkrebsregister.de

Last Name, First Name |_____| Pat.Nr. |_____| Gender |__| (1=male, 2=female) Date of birth |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

MaligID *(GCCR)*: |__|__|__|__|__| Klinik *(GCCR)*: |__|__|__|__| GPOH-PID: |__|__|__|__|__|__|__|__| *(only in Germany)*

Reporting Institution (name, address): _____

Contact Fax number: _____ Contact phone number: _____

Contact person in reporting institution: _____

Please make sure that the consent form is signed before transmitting these data !

Recurrence: ❑ **No** ❑ **Yes**

Date of first CT/ MRI showing recurrence |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Localization of recurrence:_____

_____

Status

❑ **alive**
date last seen: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
date of most recent MRI: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

(local) result:
- ❑ no evidence of disease, continuous remission
- ❑ lesion visible, dignity unclear
- ❑ residual disease, stable
- ❑ progressive disease ❑ primary lesion ❑ metastasis
- ❑ else:_____

reference review requested: ❑ No ❑ Yes

❑ **dead**
date of death: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
cause of death :
- ❑ **progressive disease**
- ❑ **surgery**
- ❑ **chemotherapy**
- ❑ **unknown**
- ❑ **else:**

please submit autopsy or mortality review, if available

If treatment for relapse or maintenance was given, please specify below

Surgery ❑ No ❑ Yes, which: ❑ **Biopsy**
❑ **Partial Resection**
❑ **complete resection**

❑ **else :** _____

_____

Date of Surgery: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Chemotherapy: ❑ No
❑ Yes, which:

_____

Start of Therapy: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
End of Therapy: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Treatment related toxicity: _____

Radiotherapy: ❑ No
❑ Yes

Start: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
End: |__|__| |__|__|.|__|__|__|__| DD.MM.YYYY

Total dosis: |__|__|__| Gy

Treatment related : ❑ None
toxicity ❑ Yes, which_____

Treatment stopped: ❑ No
❑ Yes, Date |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Reason:_____

_____ _____ _____
Stamp Date (DD.MM.YYYY) Signature