

Post-PET Initial Staging Form
National Oncologic PET Registry

Facility ID #: _____

Registry Case Number: _____

Patient Name: _____

Your patient had a PET scan on: (mm/dd/yyyy) _____.

The PET scan was done for **initial staging of (cancer type)** (auto fill cancer type from Pre-PET Form).

- A copy of the PET report is attached for your convenience.
 - After reviewing the 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.
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1. Compared to your Pre-PET assessment, your impression of the extent of the patient's cancer is? (*check one*)
 - More extensive
 - No change
 - Less extensive
2. Did the PET scan, show evidence of cancer activity that was not previously documented?
 - Yes No
 - a. If yes, is some type of tissue biopsy planned of the area? Yes No
3. Are any more tests or imaging or biopsies planned before starting treatment? Yes No
4. Did the PET scan enable you to avoid any tests or procedures? Yes No
5. Your Post-PET working clinical summary staging 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
6. In light of the PET findings, which of the following management strategies are you now planning or have you already undertaken? (*you must choose 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 concurrent biopsy and total surgical resection are planned, then mark "surgical" treatment listed below.
 - Treatment** (if treatment is selected, then also complete the following)
 - Treatment Goal:** (*check one*) Curative Palliative
 - Type(s):** (*all that apply*) Surgical Chemotherapy (including biologic modifiers)
 Radiation Other Supportive care
- Will treatment be directly provided by you?** (*check one*) Yes No

7.. 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.

8. Name of person who completed the paper form:

First Name: _____ Last Name: _____ Date: _____
