

Post-PET Treatment Monitoring 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 **treatment response monitoring of (cancer type) to chemo/radiation/or other therapy** (auto fill from Pre-PET data form the cancer type and treatment type).

- 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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- In light of the PET findings, which of the following management strategies are you now planning or have you already undertaken? (*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 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
- If treatment was selected above, please indicate if and how you will modify your therapeutic plan in light of the PET findings. (*you must check only one*)
 - Adjust the dose or duration of therapy
 - Switch to another therapy
 - No change in therapy
 - Not applicable – “Treatment” was not selected in question #1 above
- If PET were not available, would you have done some type of alternative assessment at this time?
 - Yes No
- Did the PET scan enable you to avoid more tests or procedures? Yes No
- In light of the PET results, how has the prognosis for your patient changed? (*check one*)
 - Better No change Worse
- 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.
- Name of person who completed the paper form:

First Name: _____ Last Name: _____ Date: _____
