

## Case Quality Control Form (CQCF): Colon/Rectum

V4.20

Tissue Source Site (TSS) Name: \_\_\_\_\_ TSS Identifier: \_\_\_\_\_ TSS Unique Patient #: \_\_\_\_\_

Completed By: \_\_\_\_\_ Completion Date (MM/DD/YYYY): \_\_\_\_\_

**Form Notes:** Tissue Source Site (TSS) acknowledges that the Biospecimen Core Resource (BCR) may confirm that the diagnosis of the frozen biospecimen is consistent with the primary diagnosis reported by the TSS through histopathology examination in the BCR laboratory. If the BCR identifies a possible discrepancy, the TSS authorizes the BCR to report these patient results to the TSS by means of a formal report in confidential email format for the quality assurance program of the TSS to address.

| Question #                                    | Data Element Label  | Data Entry Alternatives  | CDE ID With Working Instructions  |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
|---|---|--|---|---|---|---|---|--|--|--|--|---|--|--|--|--|--|---|
| 1   | Has this TSS received permission from the NCI to provide time intervals as a substitute for requested dates on this form? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No  | Please note that time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box to the left.<br><b>Note 1: Provided time intervals must begin with the date of initial pathologic diagnosis. (i.e., biopsy or resection)</b><br><b>Note 2: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</b> |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 2   | Histological Subtype  | <input type="checkbox"/> Colon Adenocarcinoma<br><input type="checkbox"/> Colon Mucinous Adenocarcinoma<br><input type="checkbox"/> Rectal Adenocarcinoma<br><input type="checkbox"/> Rectal Mucinous Adenocarcinoma   | 3081934<br>Indicate the histologic subtype for the colon/rectum tumor sample being submitted to TCGA.<br><b>Note: Mixed Subtypes Are Excluded For This Tumor Type. All other subtypes not listed are excluded from this study.</b>  |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 3   | Tumor Type  | <input type="checkbox"/> Primary   | 3288124<br>Confirm that the tumor being submitted to TCGA is a primary untreated malignant biospecimen.   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 4   | Anatomic Site of Frozen Biospecimen   | <table style="width: 100%; border: none;"> <tr> <th colspan="2" style="text-align: center; border: none;">Colon Subsites</th> <th style="border: none;">Rectal Subsites</th> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Cecum</td> <td style="border: none;"><input type="checkbox"/> Hepatic Flexure</td> <td style="border: none;"><input type="checkbox"/> Sigmoid Colon</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Sigmoid Colon</td> <td style="border: none;"><input type="checkbox"/> Descending Colon</td> <td style="border: none;"><input type="checkbox"/> Rectum</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Splenic Flexure</td> <td style="border: none;"><input type="checkbox"/> Transverse Colon</td> <td style="border: none;"><input type="checkbox"/> Rectosigmoid Junction</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Ascending Colon</td> <td style="border: none;"></td> <td style="border: none;"></td> </tr> </table> | Colon Subsites  |   | Rectal Subsites                               | <input type="checkbox"/> Cecum                        | <input type="checkbox"/> Hepatic Flexure    | <input type="checkbox"/> Sigmoid Colon               | <input type="checkbox"/> Sigmoid Colon     | <input type="checkbox"/> Descending Colon            | <input type="checkbox"/> Rectum          | <input type="checkbox"/> Splenic Flexure        | <input type="checkbox"/> Transverse Colon  | <input type="checkbox"/> Rectosigmoid Junction | <input type="checkbox"/> Ascending Colon |  |  | 3081961<br>Indicate the anatomic site of the frozen tumor submitted for TCGA. |
| Colon Subsites                                |   | Rectal Subsites  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Cecum                | <input type="checkbox"/> Hepatic Flexure  | <input type="checkbox"/> Sigmoid Colon   |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Sigmoid Colon        | <input type="checkbox"/> Descending Colon   | <input type="checkbox"/> Rectum  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Splenic Flexure      | <input type="checkbox"/> Transverse Colon   | <input type="checkbox"/> Rectosigmoid Junction   |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Ascending Colon      |   |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <b>Date of Cancer Sample Procurement</b>      |   |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 5   | Month of Cancer Sample Procurement  | <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (MM)   | 3008197<br>Provide the month of the procedure performed to obtain the malignant tissue submitted for TCGA.  |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 6   | Day of Cancer Sample Procurement  | <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (DD)   | 3008195<br>Provide the day of the procedure performed to obtain the malignant tissue submitted for TCGA.  |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 7   | Year of Cancer Sample Procurement   | <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> (YYYY)   | 3008199<br>Provide the year of the procedure performed to obtain the malignant tissue submitted for TCGA.   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 8   | Number of Days from Date of Initial Pathologic Diagnosis to Date of Cancer Sample Procurement                             | _____  | 3288495<br>Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of the procedure that produced the malignant sample submitted for TCGA.<br><b>Note: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</b>  |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 9   | Method of Cancer Sample Procurement   | <table style="width: 100%; border: none;"> <tr> <td style="border: none;"><input type="checkbox"/> Right Hemicolectomy</td> <td style="border: none;"><input type="checkbox"/> Pan-Procto Colectomy</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Transverse Colectomy</td> <td style="border: none;"><input type="checkbox"/> Anterior Resection of Rectum</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Left Hemicolectomy</td> <td style="border: none;"><input type="checkbox"/> Abdomino-Perineal Resection</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Sigmoid Colectomy</td> <td style="border: none;"><input type="checkbox"/> Endo-Rectal Tumor Resection</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Total Colectomy</td> <td style="border: none;"><input type="checkbox"/> Other (please specify)</td> </tr> </table>  | <input type="checkbox"/> Right Hemicolectomy  | <input type="checkbox"/> Pan-Procto Colectomy | <input type="checkbox"/> Transverse Colectomy | <input type="checkbox"/> Anterior Resection of Rectum | <input type="checkbox"/> Left Hemicolectomy | <input type="checkbox"/> Abdomino-Perineal Resection | <input type="checkbox"/> Sigmoid Colectomy | <input type="checkbox"/> Endo-Rectal Tumor Resection | <input type="checkbox"/> Total Colectomy | <input type="checkbox"/> Other (please specify) | 3103514<br>Indicate the procedure performed to obtain the malignant tissue submitted for TCGA. |  |  |  |  |   |
| <input type="checkbox"/> Right Hemicolectomy  | <input type="checkbox"/> Pan-Procto Colectomy   |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Transverse Colectomy | <input type="checkbox"/> Anterior Resection of Rectum   |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Left Hemicolectomy   | <input type="checkbox"/> Abdomino-Perineal Resection  |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Sigmoid Colectomy    | <input type="checkbox"/> Endo-Rectal Tumor Resection  |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| <input type="checkbox"/> Total Colectomy      | <input type="checkbox"/> Other (please specify)   |  |   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 10  | Other Method of Cancer Sample Procurement   | _____  | 2006730<br>If the procedure performed to obtain the malignant tissue is not included in the provided list, specify the procedure.   |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |
| 11  | Country Where Cancer Sample Was Procured  | _____  | 3203072<br>Provide the country where the tissue submitted for TCGA was procured.  |   |   |   |   |  |  |  |  |   |  |  |  |  |  |   |



| Question #                               | Data Element Label  | Data Entry Alternatives  | CDE ID With Working Instructions  |
|--|---|--|---|
| 22                                       | Will Top Slide be submitted to the BCR?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No  | 3081944<br>Indicate whether a physical top slide for the sample submitted to the BCR will be shipped with the tissue sample.<br><b>Note: Top slide definition: Slide cut directly from frozen biospecimen = mirror image of inked surface.</b>  |
| 23                                       | Will Digital Slide Image be submitted to the BCR?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No  | 3081948<br>Indicate whether a digital slide image for the sample submitted to the BCR will be shipped with the tissue sample.<br><b>Note: Physical top slides are preferred.</b>  |
| 24                                       | Top Slide / Digital Slide Image ID #  | _____  | 2321277<br>Provide the slide ID for the physical top slide OR the digital slide image being sent to the BCR.  |
| <b>Normal Information</b>                |   | Instructions: A normal control must be present to qualify.   |   |
| 25                                       | Type of Normal Control  | <input type="checkbox"/> Whole Blood<br><input type="checkbox"/> Normal Tissue<br><input type="checkbox"/> Lymphocytes (Buffy Coat)<br><input type="checkbox"/> Extracted DNA from Blood   | 3081936<br>Indicate the type of normal control submitted for this case.<br><b>Note: Whole blood is preferred. Normal tissue is only allowable with NCI approval.</b>  |
| 26                                       | Normal Identifier   | _____  | 3288138<br>Provide the TSS unique normal ID. If multiple normal control samples are submitted, each normal control needs a unique ID.   |
| 27                                       | Method of Normal Sample Procurement   | <input type="checkbox"/> Blood Draw<br><input type="checkbox"/> Total Colectomy<br><input type="checkbox"/> Sigmoid Colectomy<br><input type="checkbox"/> Left Hemicolectomy<br><input type="checkbox"/> Right Hemicolectomy<br><input type="checkbox"/> Transverse Colectomy<br><input type="checkbox"/> Pan-Procto Colectomy<br><input type="checkbox"/> Endo-Rectal Tumor Resection<br><input type="checkbox"/> Anterior Resection of Rectum<br><input type="checkbox"/> Abdomino-Perineal Resection<br><input type="checkbox"/> Other (please specify) | 3288147<br>Indicate the procedure performed to obtain the normal sample submitted for TCGA.   |
| 28                                       | Other Method of Normal Sample Procurement   | _____  | 3288151<br>If the procedure performed to obtain the normal sample is not included in the provided list, specify the procedure.  |
| <b>Date of Normal Sample Procurement</b> |   |  |   |
| 29                                       | Month of Normal Sample Procurement  | <input type="text"/> <input type="text"/> (MM)   | 3288195<br>Provide the month of the procedure performed to obtain the normal control sample for TCGA.   |
| 30                                       | Day of Normal Sample Procurement  | <input type="text"/> <input type="text"/> (DD)   | 3288196<br>Provide the day of the procedure performed to obtain the normal control sample for TCGA.   |
| 31                                       | Year of Normal Sample Procurement   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (YYYY)   | 3288197<br>Provide the year of the procedure performed to obtain the normal control sample for TCGA.  |
| 32                                       | Number of Days from Date of Initial Pathologic diagnosis to Date of Normal Sample Procurement | _____  | 3288496<br>Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of the procedure that produced the normal control sample submitted for TCGA.<br><b>Note: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</b> |
| 33                                       | Extracted DNA Quantity  | _____  | 3288185<br>If the normal control type is extracted DNA from blood, provide the quantity (µg) of the normal control sample sent to the BCR for TCGA.   |
| 34                                       | Extracted DNA Quantification Method   | _____  | 3288186<br>If the normal control type is extracted DNA from blood, provide the quantification method of the normal control sample sent to the BCR for TCGA.   |
| 35                                       | Extracted DNA Concentration   | _____  | 3288187<br>If the normal control type is extracted DNA from blood, provide the concentration (µg/ µL) of the normal control sample sent to the BCR for TCGA.  |
| 36                                       | Extracted DNA Volume  | _____  | 3288188<br>If the normal control type is extracted DNA from blood,  |

| Question #   | Data Element Label  | Data Entry Alternatives   | CDE ID With Working Instructions  |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
|--|---|---|---|--|------------------------|--------------------------------|--|--|--|---|---------------------------------|--|---|--|--|--|---|---|--|--|--|
|  |   |   | provide the volume (μL) of the normal control sample sent to the BCR for TCGA.  |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 37   | Anatomic Site of Normal Tissue  | <table border="0"> <tr> <td colspan="2" style="text-align: center;"><b>Colon Subsites</b></td> <td style="text-align: center;"><b>Rectal Subsites</b></td> </tr> <tr> <td><input type="checkbox"/> Cecum</td> <td><input type="checkbox"/> Ascending Colon</td> <td><input type="checkbox"/> Sigmoid Colon</td> </tr> <tr> <td><input type="checkbox"/> Sigmoid Colon</td> <td><input type="checkbox"/> Transverse Colon</td> <td><input type="checkbox"/> Rectum</td> </tr> <tr> <td><input type="checkbox"/> Splenic Flexure</td> <td><input type="checkbox"/> Descending Colon</td> <td><input type="checkbox"/> Rectosigmoid Junction</td> </tr> <tr> <td><input type="checkbox"/> Hepatic Flexure</td> <td></td> <td><input type="checkbox"/> Other (please specify)</td> </tr> <tr> <td><input type="checkbox"/> Other (please specify)</td> <td></td> <td></td> </tr> </table> | <b>Colon Subsites</b>   |  | <b>Rectal Subsites</b> | <input type="checkbox"/> Cecum | <input type="checkbox"/> Ascending Colon | <input type="checkbox"/> Sigmoid Colon | <input type="checkbox"/> Sigmoid Colon | <input type="checkbox"/> Transverse Colon | <input type="checkbox"/> Rectum | <input type="checkbox"/> Splenic Flexure | <input type="checkbox"/> Descending Colon | <input type="checkbox"/> Rectosigmoid Junction | <input type="checkbox"/> Hepatic Flexure |  | <input type="checkbox"/> Other (please specify) | <input type="checkbox"/> Other (please specify) |  |  | 3081938<br>If the normal control type is normal tissue, indicate the anatomic site of the non-neoplastic control tissue submitted for TCGA. Note: Site matched is preferred. |
| <b>Colon Subsites</b>  |   | <b>Rectal Subsites</b>  |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| <input type="checkbox"/> Cecum   | <input type="checkbox"/> Ascending Colon  | <input type="checkbox"/> Sigmoid Colon  |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| <input type="checkbox"/> Sigmoid Colon   | <input type="checkbox"/> Transverse Colon   | <input type="checkbox"/> Rectum   |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| <input type="checkbox"/> Splenic Flexure   | <input type="checkbox"/> Descending Colon   | <input type="checkbox"/> Rectosigmoid Junction  |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| <input type="checkbox"/> Hepatic Flexure   |   | <input type="checkbox"/> Other (please specify)   |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| <input type="checkbox"/> Other (please specify)  |   |   |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 38   | Other Anatomic Site of Normal Tissue  | _____   | 3288189<br>If the normal control type is normal tissue and the anatomic site is not included in the provided list, specify the site of the non-neoplastic control.  |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 39   | Proximity of Normal Tissue to Tumor   | <input type="checkbox"/> Distal (≥ 2 cm) from the primary tumor   | 3088708<br>If normal tissue is being submitted, confirm that the normal tissue is ≥ 2.0cm from the primary tumor.<br><b>Note: Adjacent and/or tissue of unknown proximity are not accepted for this tissue type.</b>  |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 40   | Normal Slide ID #   | _____   | 3288217<br>If the normal control type is normal tissue, provide the slide ID for the physical top slide OR the digital slide image of the normal control being sent to the BCR.   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| <b>Verification:</b> By providing the information below, the Principal Investigator acknowledges that the information provided by the institution is true and correct and has been quality controlled. |   |   |   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 41   | Name of Pathologist   | _____   | 3288225<br>Provide the name of the Pathologist that reviewed and prescreened the top slide and provided the information for all previous sections.  |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 42   | Date of Pathologist Review  | □□/□□/□□□□ (MM/DD/YYYY)   | 3288224<br>Provide the date of the pathology prescreening review performed by the TSS pathologist above.  |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 43   | Number of Days from Date of Initial Pathologic Diagnosis to Date of Pathological Review   | _____   | 3288497<br>Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of the pathological review performed as part of the submission process for TCGA.<br><b>Note: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</b>                                     |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 44   | Percent Tumor Nuclei meets TCGA metrics?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No   | 3288520<br>Confirm that the malignant sample submitted to the BCR meets the current tumor nuclei metrics for TCGA.<br><b>Note: Check with the BCR to confirm the current acceptable TCGA metrics.</b>   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 45   | Percent Tumor Necrosis meets TCGA metrics?  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No   | 3288524<br>Confirm that the malignant sample submitted to the BCR meets the current necrosis metrics for TCGA.<br><b>Note: Check with the BCR to confirm the current acceptable TCGA metrics.</b>   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 46   | De-Identified Pathology Report Submitted?   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No   | 3288292<br>Confirm that a de-identified pathology report will be sent to BCR prior to or with the shipment of the physical samples.   |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |
| 47   | Is the histologic diagnosis on the CQCF (as determined by the TSS pathology review of the TCGA frozen section top slide) consistent with the histology listed in the final diagnosis on the | <input type="checkbox"/> Yes (skip related question below).<br><input type="checkbox"/> No  | 3288300<br>Confirm that the diagnosis provided on this CQCF for the tumor sample being submitted to TCGA is consistent with the diagnosis found on the patient's pathology report for the tumor being sent to the BCR.<br><b>Note: The diagnosis is considered to be consistent if at least one of the following criteria are met:</b><br><b>1) Diagnosis on the CQCF is identical to the pathology report for the tumor being sent to the BCR.</b> |  |                        |                                |  |  |  |   |                                 |  |   |  |  |  |   |   |  |  |  |

| Question #             | Data Element Label   | Data Entry Alternatives  | CDE ID With Working Instructions  |
|------------------------|--|--|---|
|                        | pathology report?  |  | <p>2) <i>Diagnosis on the CQCF includes at least one of the subtypes listed on the pathology report and all subtypes on the pathology report are acceptable for TCGA.</i></p> <p>3) <i>Diagnosis on the CQCF is "histology, NOS" (i.e. Adenocarcinoma, NOS) and the pathology report lists a specific subtype within the same histological group.</i></p> <p>4) <i>Diagnosis on the CQCF indicates "Mixed Subtype" and the pathology report lists two or more acceptable subtypes, provided that percent subtype(s) meet applicable TCGA disease-specific requirements.</i></p>   |
| 48                     | If the diagnosis on this form is not consistent with the provided pathology report, indicate the reason for the inconsistency. | <input type="checkbox"/> Macrodissection performed at TSS to select for region containing an acceptable TCGA diagnosis<br><input type="checkbox"/> Pathology analysis at TSS determined a specific histological subtype different from original pathology report (see note at right)<br><input type="checkbox"/> Pathology review of frozen section for TCGA determined histological subtype different from the pathology report (see note at right) | <p>3288315</p> <p>If the diagnosis provided on this form is not consistent with the diagnosis found on the patient's pathology report for the tumor being submitted for TCGA, specify a reason for this inconsistency.</p> <p><b>Note: If a TSS pathology review of the TCGA committed sample resulted in a different histological subtype than what is documented on the pathology report, an amendment to the pathology report should be submitted when the sample is shipped to the BCR; or in the absence of an amended pathology report, the TSS must complete and submit an electronic copy of the "TCGA Pathologic Diagnosis Discrepancy Form." In the case of diagnosis modifications, institution protocol should be followed for proper quality assurance</b></p> |
| 49                     | History of Neo-Adjuvant Treatment to Tumor Specimen Submitted for TCGA   | <input type="checkbox"/> No<br><input type="checkbox"/> Radiation Prior to Sample Procurement<br><input type="checkbox"/> Pharmaceutical Treatment Prior to Sample Procurement<br><input type="checkbox"/> Both Pharmaceutical and Radiation Treatment Prior to Sample Procurement   | <p>3382737</p> <p>Indicate whether the patient received therapy for this cancer prior to sample procurement of the tumor submitted for TCGA. If the patient did receive treatment for this cancer prior to procurement, the TSS should contact the BCR for further instructions.</p> <p><b>Note: Systemic treatment and certain localized therapies (those administered to the same site as the TCGA submitted tissue) given prior to procurement of the sample submitted for TCGA are exclusionary.</b></p>  |
| 50                     | Has the Patient Had Any Prior Cancer Diagnosed?  | <input type="checkbox"/> No<br><input type="checkbox"/> History of Prior Malignancy<br><input type="checkbox"/> History of Synchronous / Bilateral Malignancy  | <p>3382736</p> <p>Indicate whether the patient has a history of prior malignancies.</p> <p><b>Note 1: If this question cannot be answered because the answer is unknown, the case will be excluded from TCGA.</b></p> <p><b>Note 2: If the patient has any history of prior malignancies, including synchronous or bilateral malignancies, please complete an "Other Malignancy Form" for each malignancy diagnosed prior to the procurement of the tissue submitted for TCGA. If the patient has a history of multiple diagnoses of basal and/or squamous cell skin cancers, complete an "Other Malignancy Form" for the first diagnosis for each of these types.</b></p>  |
| 51                     | Consent Status   | <input type="checkbox"/> Consented<br><input type="checkbox"/> Deceased<br><input type="checkbox"/> Exemption 4<br><input type="checkbox"/> Waiver   | <p>3288361</p> <p>Indicate whether the patient was formally consented, consented by death, or if the case has an exemption or waiver for consent</p> <p><b>Note: Either the Date of Consent or the Date of Death must be provided to qualify.</b></p>   |
| <b>Date of Consent</b> |  |  |   |
| 52                     | Month of Consent   | <input type="checkbox"/> <input type="checkbox"/> (MM)   | <p>3081955</p> <p>If the patient was formally consented, provide the month of consent.</p> <p><b>Note: Do not answer this question if the patient consented by death only.</b></p>  |
| 53                     | Day of Consent   | <input type="checkbox"/> <input type="checkbox"/> (DD)   | <p>3081957</p> <p>If the patient was formally consented, provide the day of consent.</p> <p><b>Note: Do not answer this question if the patient consented by death only.</b></p>  |
| 54                     | Year of Consent  | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> (YYYY)   | <p>3081959</p>  |

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|----------------------|---|--|---|
|                      |   |  | If the patient was formally consented, provide the year of consent.<br><b>Note: Do not answer this question if the patient consented by death only.</b>   |
| 55                   | Number of Days from Date of Initial Pathologic diagnosis to Date of Consent | _____  | 3288498<br>If the patient formally consented, provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of the patient's formal consent.<br><b>Note: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</b>  |
| <b>Date of Death</b> |   |  |   |
| 56                   | Month of Death  | <input type="text"/> <input type="text"/> (MM)   | 2897026<br>If the patient consented by death, provide the month of death.<br><b>Note: If the patient formally consented, only supply the date the patient consent.</b>  |
| 57                   | Day of Death  | <input type="text"/> <input type="text"/> (DD)   | 2897028<br>If the patient consented by death, provide the day of death<br><b>Note: If the patient formally consented, only supply the date the patient consent.</b>   |
| 58                   | Year of Death   | <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> (YYYY) | 2897030<br>If the patient consented by death, provide the year of death.<br><b>Note: If the patient formally consented, only supply the date the patient consent.</b>   |
| 59                   | Number of Days from Date of Initial Pathologic diagnosis to Date of Death   | _____  | 3288499<br>If the patient consented by death, provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date of the patient's death.<br><b>Note 1: Only provide interval data if you have received permission from the NCI to provide time intervals as a substitute for requested dates on this form.</b><br><b>Note 2: If the patient formally consented prior to death, do not answer this question. Only answer the question above that asks for the number of days between the date of diagnosis and the date of the patient consent.</b> |

Comments:

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Principal Investigator Name: \_\_\_\_\_ Principal Investigator Signature: \_\_\_\_\_

Date Signed (MM/DD/YYYY): \_\_\_\_\_