

## Enrollment Form Sarcoma (SARC)

**Instructions:** The Enrollment Form should be completed for each TCGA qualified case, upon qualification notice from the BCR. All information provided on this form should include activity and known history from the date of initial diagnosis to the most recent date of contact with the patient ("Date of Initial Pathologic Diagnosis" and "Date of Last Contact" on this form).

Questions regarding this form should be directed to the Tissue Source Site's primary Clinical Outreach Contact at the BCR.

**Please note the following definitions for the "Unknown" and "Not Evaluated" answer options on this form.**

**Unknown:** This answer option should only be selected if the TSS does not know this information after all efforts to obtain the data have been exhausted. If this answer option is selected for a question that is part of the TCGA required data set, the TSS must complete a discrepancy note providing a reason why the answer is unknown.

**Not Evaluated:** This answer option should only be selected by the TSS if it is known that the information being requested cannot be obtained. This could be because the test in question was never performed on the patient or the TSS knows that the information requested was never disclosed.

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

Completed By (Interviewer Name in OpenClinica): \_\_\_\_\_ Completed Date: \_\_\_\_\_

### General Information

#	Data Element	Entry Alternatives	Working Instructions
1	Is this a prospective tissue collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the TSS providing tissue is contracted for prospective tissue collection. If the submitted tissue was collected for the specific purpose of TCGA, the tissue has been collected prospectively. <a href="#">3088492</a>
2	Is this a retrospective tissue collection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Indicate whether the TSS providing tissue is contracted for retrospective tissue collection. If the submitted tissue was collected prior to the date the TCGA contract was executed, the tissue has been collected retrospectively. <a href="#">3088528</a>

### Patient Information

#### Date of Birth

3*	Date of Birth	_____ <i>Month Day Year</i>	Provide the date the patient was born. <a href="#">2896950</a> (Month), <a href="#">2896952</a> (Day), <a href="#">2896954</a> (Year)
4*	Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	Provide the patient's gender using the defined categories. <a href="#">2200604</a>
5	Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander: <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	Provide the patient's race using the defined categories. <a href="#">2192199</a>  <i>American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.</i> <i>Asian: A person having origins in any of the original peoples of the far East, Southeast Asia, or in the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.</i> <i>White: A person having origins in any of the original peoples of the far Europe, the Middle East, or North Africa.</i> <i>Black or African American: A person having origins in any of any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."</i> <i>Native Hawaiian or other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.</i> <i>Not Evaluated: Not provided or available.</i> <i>Unknown: Could not be determined or unsure.</i>
6	Ethnicity	<input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Evaluated <input type="checkbox"/> Unknown	Provide the patient's ethnicity using the defined categories. <a href="#">2192217</a>  <i>Not Hispanic or Latino: A person not meeting the definition of Hispanic or Latino.</i> <i>Hispanic or Latino: A person of Mexican, Puerto Rican, Cuban, Central or South American or other Spanish culture or origin, regardless of race.</i> <i>Not Evaluated: Not provided or available.</i> <i>Unknown: Could not be determined or unsure.</i>

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7	History of Other Malignancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Indicate whether the patient was, at any time in their life, diagnosed with a malignancy prior or synchronous to the diagnosis of the specimen submitted for TCGA. If the patient has had a prior or synchronous malignancy, an additional form (the "Other Malignancy Form") must be completed for each prior or synchronous malignancy. If the OMF was completed and submitted with the Initial Case Quality Control Form, the OMF does not need to be submitted a second time.</p> <p><a href="#">3382736</a></p> <p>If this question cannot be answered because the answer is unknown, the case will be excluded from TCGA.</p> <p>If the patient has a history of multiple diagnoses of basal or squamous cell skin cancer, complete an OMF for the first diagnosis for each of these types.</p>
8	Neo-adjuvant (Pre-Operative) Therapy <i>for Tumor Submitted for TCGA</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Indicate whether the patient received neo-adjuvant treatment (radiation, pharmaceutical, or both) prior to the collection of the tumor that yielded the sample submitted for TCGA.</p> <p><a href="#">3382737</a></p> <p>Systemic therapy and certain localized therapies (those administered to the same site as the TCGA submitted tissue) given prior to the collection of the sample submitted for TCGA is exclusionary.</p>
9	Tumor Status <i>(at time of last contact or death)</i>	<input type="checkbox"/> Tumor free <input type="checkbox"/> With tumor <input type="checkbox"/> Unknown	<p>Indicate whether the patient was tumor/disease free at the date of last contact or death.</p> <p><a href="#">2759550</a></p>
10	Vital Status <i>(at date of last contact)</i>	<input type="checkbox"/> Living <input type="checkbox"/> Deceased	<p>Indicate whether the patient was living or deceased at the date of last contact.</p> <p><a href="#">5</a></p>
11	Date of Last Contact	_____ <i>Month Day Year</i>	<p>If the patient is living, provide the date of last contact with the patient (as reported by the patient, medical provider, family member, or caregiver).</p> <p><a href="#">2897020</a> (Month), <a href="#">2897022</a> (Day), <a href="#">2897024</a> (Year)</p>
12	Date of Death	_____ <i>Month Day Year</i>	<p>If the patient is deceased, provide the date of death.</p> <p><a href="#">2897026</a> (Month), <a href="#">2897028</a> (Day), <a href="#">2897030</a> (Year)</p>
13	Adjuvant (Post-Operative) Radiation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p>Indicate whether the patient had adjuvant/ post-operative radiation therapy.</p> <p><a href="#">2005312</a></p> <p>If the patient did have adjuvant radiation, the Radiation Supplemental Form should be completed.</p>
14	Adjuvant (Post-Operative) Pharmaceutical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p>Indicate whether the patient had adjuvant/ post-operative pharmaceutical therapy.</p> <p><a href="#">2785850</a></p> <p>If the patient did have adjuvant pharmaceutical therapy, the Pharmaceutical Supplemental Form should be completed.</p>

### Primary Tumor Pathologic/ Prognostic Information

#	Data Element	Entry Alternatives	Working Instructions
15	Histological Type	<input type="checkbox"/> Dedifferentiated liposarcoma <input type="checkbox"/> Leiomyosarcoma (LMS)* <input type="checkbox"/> Undifferentiated Pleomorphic Sarcoma (UPS), NOS <ul style="list-style-type: none"> <li><input type="checkbox"/> Pleomorphic 'MFH' / Undifferentiated pleomorphic sarcoma</li> <li><input type="checkbox"/> Giant cell 'MFH' / Undifferentiated pleomorphic sarcoma with giant cells</li> <li><input type="checkbox"/> Inflammatory 'MFH' / Undifferentiated pleomorphic sarcoma with prominent inflammation</li> </ul> <input type="checkbox"/> Malignant Peripheral Nerve Sheath Tumors (MPNST) <input type="checkbox"/> Desmoid Tumor <input type="checkbox"/> Myxofibrosarcoma <input type="checkbox"/> Synovial Sarcoma - Monophasic <input type="checkbox"/> Synovial Sarcoma - Biphasic <input type="checkbox"/> Synovial Sarcoma - Poorly differentiated	<p>Using the patient's pathology/laboratory report, select the histology and/or subtype of the tumor submitted for TCGA.</p> <p><a href="#">3081934</a></p> <p>If the histological type is Leiomyosarcoma, please complete the three additional questions below. For all other histological subtypes these three questions can be skipped.</p>

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#	Data Element	Entry Alternatives	Working Instructions
16	Leiomyosarcoma: Histological Subtype	<input type="checkbox"/> Well-differentiated leiomyosarcoma (resembling leiomyoma) <input type="checkbox"/> Conventional leiomyosarcoma <input type="checkbox"/> Poorly differentiated/ pleomorphic/ epithelioid leiomyosarcoma	If the histological subtype is Leiomyosarcoma, using the patient's pathology/laboratory report, select the histological subtype of the tumor submitted for TCGA. <a href="#">2831122</a>
17	Leiomyosarcoma: Uterine Involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If the histological subtype is Leiomyosarcoma, using the patient's pathology/ laboratory report, indicate whether there was uterine involvement. <a href="#">2775554</a>
18	Leiomyosarcoma: Major Vessel Involvement	<input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes - NOS <input type="checkbox"/> Yes - Jugular/carotid <input type="checkbox"/> Yes - Subclavicular <input type="checkbox"/> Yes - Superior vena cava/chest <input type="checkbox"/> Yes - Inferior vena cava <input type="checkbox"/> Yes - Brachial vein/ axillary vein <input type="checkbox"/> Yes - Pelvic vein/ common/external/ iliac <input type="checkbox"/> Yes - Common/ superficial femoral vein <input type="checkbox"/> Yes - Renal vein	If the histological subtype is Leiomyosarcoma, using the patient's pathology/ laboratory report, indicate whether there was major vessel involvement. If the patient did have major vessel involvement, indicate where it was located. <a href="#">3243330</a>
19	Synovial Sarcoma: SS18-SSX Fusion Status	<input type="checkbox"/> Positive - SS18-SSX1 <input type="checkbox"/> Positive - SS18-SSX2 <input type="checkbox"/> Positive - Subtype <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Using the patient's pathology/cytogenetics/molecular diagnostics laboratory report, indicate whether evidence of an SS18-SSX fusion was reported and the testing method. <a href="#">3733516</a>
20	Synovial Sarcoma: SS18-SSX Testing Method	<input type="checkbox"/> RT-PCR <input type="checkbox"/> FISH for SS18 split <input type="checkbox"/> Both <input type="checkbox"/> Unknown	Using the patient's pathology/cytogenetics/molecular diagnostics laboratory report, indicate the testing method for SS18-SSX. <a href="#">3733517</a>
21	MPNST: Does the patient have neurofibromatosis?	<input type="checkbox"/> NF1 <input type="checkbox"/> NF2 <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's medical records, indicate whether the patient had neurofibromatosis. <a href="#">3733521</a>
22	MPNST: If the patient has neurofibromatosis, is it familial or sporadic?	<input type="checkbox"/> Familial <input type="checkbox"/> Sporadic <input type="checkbox"/> Unknown	If the patient had neurofibromatosis, indicate if it was known to be familial or sporadic. <a href="#">3733535</a>
23	MPNST: Pre-existing plexiform neurofibroma at site of MPNST?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's medical records, indicate whether the patient had pre-existing plexiform neurofibroma at site of MPNST. <a href="#">3733551</a>
24	MPNST: Was NF1 Genetic Testing Performed?	<input type="checkbox"/> Yes, mutations identified <input type="checkbox"/> Yes, mutations were NOT identified <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's medical records, indicate whether NF1 genetic testing was performed. <a href="#">3733556</a>
25	MPNST: If NF1 genetic testing was performed and mutations were identified, please identify the specific mutations.	_____	If NF1 genetic testing was performed, provide any specific mutations that were identified. <a href="#">3733558</a>
26	Tumor Depth	<input type="checkbox"/> Superficial <input type="checkbox"/> Deep <input type="checkbox"/> Unknown	Using the patient's pathology/ laboratory report, indicate the depth of the tumor. <a href="#">3808610</a>
27	Primary Site of Disease	<input type="checkbox"/> Head & Neck <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Other, specify <input type="checkbox"/> Chest <input type="checkbox"/> Lung/pleura <input type="checkbox"/> Mediastinum <input type="checkbox"/> Chest wall <input type="checkbox"/> Retroperitoneum/ Upper abdominal <input type="checkbox"/> Retroperitoneum <input type="checkbox"/> Intraabdominal <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Colon <input type="checkbox"/> Gastric	Using the patient's pathology/laboratory report, select the anatomic site of disease of the tumor submitted for TCGA. <a href="#">2735776</a> <b>If the histological type is Leiomyosarcoma and the primary site of disease is skin, this case is excluded.</b>

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#	Data Element	Entry Alternatives	Working Instructions	
		<input type="checkbox"/> Diaphragm <input type="checkbox"/> Breast <input type="checkbox"/> Other, specify <input type="checkbox"/> Superficial Trunk <input type="checkbox"/> Abdominal wall <input type="checkbox"/> Buttock <input type="checkbox"/> Flank <input type="checkbox"/> Back <input type="checkbox"/> Other, specify <input type="checkbox"/> Upper Extremity <input type="checkbox"/> Shoulder/axilla <input type="checkbox"/> Upper arm/elbow <input type="checkbox"/> Forearm <input type="checkbox"/> Hand/wrist <input type="checkbox"/> Other, specify <input type="checkbox"/> Lower Extremity <input type="checkbox"/> Thigh/knee <input type="checkbox"/> Groin <input type="checkbox"/> Lower leg/calf <input type="checkbox"/> Foot/ankle <input type="checkbox"/> Other, specify	<input type="checkbox"/> Duodenum <input type="checkbox"/> Small Intestines <input type="checkbox"/> Pancreas <input type="checkbox"/> Other, specify <input type="checkbox"/> Lower abdominal/ Pelvic <input type="checkbox"/> Pelvic <input type="checkbox"/> Bladder <input type="checkbox"/> Prostate <input type="checkbox"/> Rectum <input type="checkbox"/> Spermatic Cord <input type="checkbox"/> Scrotum/testis <input type="checkbox"/> Other, specify <input type="checkbox"/> Gynecological <input type="checkbox"/> Uterus <input type="checkbox"/> Ovary <input type="checkbox"/> Cervix <input type="checkbox"/> Fallopian tube <input type="checkbox"/> Other, specify	
28	Other Primary Site of Disease	_____	If the primary site of disease on the pathology/laboratory report is not available or does not specifically match the provided sites above, describe the site(s) of disease. <a href="#">2584114</a>	
29	Date of Initial Pathologic Diagnosis	_____ <i>Month Day Year</i>	Provide the date the patient was initially pathologically diagnosed with the malignancy submitted for TCGA. <a href="#">2896956</a> (Month), <a href="#">2896958</a> (Day), <a href="#">2896960</a> (Year)	
30	Margin Status	<input type="checkbox"/> Positive (+) $\leq 1mm$ <input type="checkbox"/> Negative (-) <input type="checkbox"/> Unknown	Provide the margin status after the patient's first surgical procedure. <a href="#">3114007</a>	
31	Residual Tumor	<input type="checkbox"/> RX <input type="checkbox"/> R0	<input type="checkbox"/> R1 <input type="checkbox"/> R2	Using the patient's pathology/laboratory report, select the residual tumor status after the surgical resection. <a href="#">2608702</a>
32	Necrosis of Total Tumor	<input type="checkbox"/> 0% (no necrosis or no mention of necrosis) <input type="checkbox"/> <10% ("focal necrosis") <input type="checkbox"/> Moderate Necrosis ( $\geq 10$ , <50%) <input type="checkbox"/> Extensive Necrosis (>50%) <input type="checkbox"/> Complete or if listed (>99% or profound therapy effect)	Using the patient's pathology/laboratory report, select the necrosis of the total tumor. If a specific percentage of necrosis is available, answer the following question. <a href="#">3300612</a>	
33	Percent Necrosis of Total Tumor	_____	Indicate the percent necrosis of the entire tumor as recorded either at the time of resection or during subsequent analysis. <a href="#">2841237</a>	
34	Mitotic Count	_____ (number mitoses per 10 high power fields)	Using the patient's pathology/laboratory report, provide the patient's mitotic count. This should be the number mitoses per 10 high powered fields (10 HPF $\cong$ 2.2 mm <sup>2</sup> ). <a href="#">3227319</a>	
35	Is Disease Multifocal?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's pathology/laboratory report, indicate whether the disease was multifocal. <a href="#">64356</a>	
36	Number of Discontiguous Lesions	_____	Using the patient's pathology/laboratory report, provide the number of discontiguous lesions. <a href="#">3162604</a>	
<b>Tumor Size: Include both well-differentiated and de-differentiated components.</b>				
<i>(If there were multiple lesions, complete this question for each lesion)</i>				
37	Radiologic Tumor Size	Radiologic Length	_____ (cm)	Provide the length for this tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection. <a href="#">3528021</a>
		Radiologic Width	_____ (cm)	Provide the width for this tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection. <a href="#">3528033</a>
		Radiologic Depth	_____ (cm)	Provide the depth for this tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection. <a href="#">3528032</a>

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#	Data Element	Entry Alternatives	Working Instructions
38	Pathologic Tumor Size	Pathologic Length _____ (cm)	Provide the length for this tumor, when available as examined pathologically at the time of the surgical resection. <a href="#">3528034</a>
		Pathologic Width _____ (cm)	Provide the width for this tumor, when available as examined pathologically at the time of the surgical resection. <a href="#">3528041</a>
		Pathologic Depth _____ (cm)	Provide the depth for this tumor, when available as examined pathologically at the time of the surgical resection. <a href="#">3528040</a>
39	Radiologic Tumor Burden	_____	Provide the sum of the maximum diameter of the primary tumors as reported on the CT scan or MRI immediately preceding surgical resection. This should include both well-differentiated and de-differentiated components. <a href="#">3162636</a>
40	Pathologic Tumor Burden	_____	Provide the sum of the maximum diameter of the primary tumors as examined pathologically at the time of the surgical resection. This should include both well-differentiated and de-differentiated components. <a href="#">3162641</a>
41	Locoregional Recurrence	<input type="checkbox"/> Yes <span style="margin-left: 150px;"><input type="checkbox"/> Unknown</span> <input type="checkbox"/> No	Indicate whether the patient had a local recurrence associated with the tumor submitted for TCGA. <a href="#">62652</a>
42	Metastasis (Radiologic Evidence)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient was diagnosed with a distant metastasis with radiologic evidence. <a href="#">65384</a>
43	Location of Metastasis	<input type="checkbox"/> Lung <span style="margin-left: 150px;"><input type="checkbox"/> Unknown</span> <input type="checkbox"/> Bone <span style="margin-left: 150px;"><input type="checkbox"/> Other, specify</span> <input type="checkbox"/> Liver	If the patient had a metastatic tumor associated with the diagnosis of the tumor submitted for TCGA, provide the site of the metastasis. If there was more than one metastatic site, select all that apply. <a href="#">3124499</a>
44	Other Location of Metastasis	_____	If the site of the metastasis was not included in the list provided, please provide the site. <a href="#">3124503</a>
45	Contiguous Organ/ Structure Resection	<input type="checkbox"/> Adrenal <span style="margin-left: 150px;"><input type="checkbox"/> Kidney</span> <input type="checkbox"/> Bladder <span style="margin-left: 150px;"><input type="checkbox"/> Liver</span> <input type="checkbox"/> Colon <span style="margin-left: 150px;"><input type="checkbox"/> Small Bowel</span> <input type="checkbox"/> Inferior vena cava (IVC) <span style="margin-left: 150px;"><input type="checkbox"/> Spleen</span> <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify	If the patient had a contiguous organ/ structure removed, indicate the location of the contiguous organ. <a href="#">3162811</a>
46	Other Contiguous Organ/ Structure Resection	_____	If the site of the contiguous organ/ structure was not included in the list provided, describe the organ. <a href="#">3162812</a>
47	Contiguous Organ Invaded	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the tumor invaded a contiguous organ. <a href="#">3162817</a>
48	Dedifferentiated Liposarcoma: Prior Diagnosis of Well Differentiated Liposarcoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had a prior diagnosis of well differentiated liposarcoma. <a href="#">3162681</a> <b>Only answer this question if the histological subtype for tumor submitted to TCGA is dedifferentiated liposarcoma. All other subtypes can skip the remaining questions.</b>
<b>Date of <a href="#">Primary Diagnosis</a> of Well Differentiated Liposarcoma</b>			
49	Date Primary Diagnosis of Well Differentiated Liposarcoma	_____/_____/_____ Month Day Year	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the date of this diagnosis. <a href="#">3162688</a> (Month), <a href="#">3162689</a> (Day), <a href="#">3162690</a> (Year)
<b>Date of <a href="#">Resection</a> of Well Differentiated Liposarcoma</b>			
50	Date Resection of Well Differentiated Liposarcoma	_____/_____/_____ Month Day Year	If the patient had a prior diagnosis of well differentiated liposarcoma, provide the date the tumor was removed. <a href="#">3162705</a> (Month), <a href="#">3162706</a> (Day), <a href="#">3162707</a> (Year)

**New Tumor Event Information** Complete this section if the patient had a new tumor event. If the patient did not have a new tumor event (or if the TSS does not know) indicate this in the question below, and the remainder of this section can be skipped.

**Note:** The New Tumor Event section on OpenClinica can be completed multiple times, if the patient had multiple New Tumor Events.

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#	Data Element	Entry Alternatives	Working Instructions
51	New Tumor Event After Initial Treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient had a new tumor event (e.g. metastatic, recurrent, or new primary tumor) after their initial treatment. <a href="#">3121376</a>
52	Type of New Tumor Event	<input type="checkbox"/> Locoregional/Recurrence <input type="checkbox"/> Distant Metastasis <input type="checkbox"/> New Primary Tumor	Indicate whether the patient's new tumor event was a locoregional recurrence, a distant metastasis or a new primary tumor. <a href="#">3119721</a>
53	Site of New Tumor Event	<input type="checkbox"/> Lung <input type="checkbox"/> Bone <input type="checkbox"/> Liver <input type="checkbox"/> Brain <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	Indicate the site of this new tumor event. <a href="#">3108271</a>
54	Other Site of New Tumor Event	_____	If the patient had a new tumor event and the site of this tumor was not included in the provided list, describe the site. <a href="#">3128033</a>
<i>Date of New Tumor Event after Initial Treatment</i>			
55	Date of New Tumor Event	_____ <i>Month Day Year</i>	If the patient had a new tumor event, provide the date of diagnosis for this new tumor event. <a href="#">3104044</a> (Month), <a href="#">3104042</a> (Day), <a href="#">3104046</a> (Year)
56	Additional Surgery for New Tumor Event	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's medical records, indicate whether the patient had surgery for the new tumor event in question. <a href="#">3427611</a>
<i>Date of Additional Surgery for New Tumor Event (when applicable)</i>			
57	Date of Additional Surgery for New Tumor Event	_____ <i>Month Day Year</i>	If the patient had surgery for the new tumor event, provide the date this surgery was performed. <a href="#">3427612</a> (Month), <a href="#">3427613</a> (Day), <a href="#">3427614</a> (Year)
58	Residual Tumor after Surgery for New Tumor Event	<input type="checkbox"/> RX <input type="checkbox"/> R0 <input type="checkbox"/> R1 <input type="checkbox"/> R2	Using the patient's pathology/laboratory report, select the residual tumor status after the surgical resection for the new tumor event. <a href="#">3104061</a>
59	Is Disease Multifocal?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Using the patient's pathology/laboratory report, indicate whether the new tumor was multifocal. <a href="#">3524937</a>
60	Number of Discontiguous Lesions	_____	Using the patient's pathology/laboratory report, provide the number of discontiguous lesions for the new tumor. <a href="#">3526717</a>
61	Radiologic Size of New Tumor	Radiologic Length _____ (cm)	Provide the length for the new tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection of the new tumor. <a href="#">3527990</a>
		Radiologic Width _____ (cm)	Provide the width for the new tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection of the new tumor. <a href="#">3527997</a>
		Radiologic Depth _____ (cm)	Provide the depth for the new tumor, when available as reported on the CT scan or MRI, immediately preceding the surgical resection of the new tumor. <a href="#">3527996</a>
62	Pathologic Size of New Tumor	Pathologic Length _____ (cm)	Provide the length for the new tumor, when available as examined pathologically at the time of the surgical resection of the new tumor. <a href="#">3528003</a>
		Pathologic Width _____ (cm)	Provide the width for the new tumor, when available as examined pathologically at the time of the surgical resection of the new tumor. <a href="#">3528020</a>
		Pathologic Depth _____ (cm)	Provide the depth for the new tumor, when available as examined pathologically at the time of the surgical resection of the new tumor. <a href="#">3528004</a>
63	Radiologic Burden of New Tumor	_____	Provide the sum of the maximum diameter of the new tumors as reported on the CT scan or MRI immediately preceding surgical resection. This should include both well-differentiated and de-differentiated components. <a href="#">3526720</a>

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#	Data Element	Entry Alternatives	Working Instructions
<u>64</u>	Pathologic Burden of New Tumor	_____	Provide the sum of the maximum diameter of the new tumors as examined pathologically at the time of the surgical resection. This should include both well-differentiated and de-differentiated components. <a href="#">3526721</a>
<u>65</u>	Is the New Tumor Well-Differentiated or De-Differentiated? (Check all that apply)	<input type="checkbox"/> Well-Differentiated <input type="checkbox"/> De-Differentiated	Indicate whether the newly diagnosed tumor is well-differentiated or de-differentiated. <a href="#">3194001</a>
<u>66</u>	Additional treatment for New Tumor Event: <i>Radiation Therapy</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received radiation treatment for this new tumor event. <a href="#">3427615</a>
<u>67</u>	Additional treatment for New Tumor Event: <i>Pharmaceutical Therapy</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Indicate whether the patient received pharmaceutical treatment for this new tumor event. <a href="#">3427616</a>

**Time Intervals:** The following questions are only to be answered if the Tissue Source Site is unable to provide the dates requested on this form.  
**Please 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.

i	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 <input type="checkbox"/> No	<b>Please Note:</b> The time intervals must be recorded in place of dates where designated throughout this form if you have selected "yes" in the box. Provided time intervals must begin with the date of initial pathologic diagnosis (i.e., biopsy or resection).
ii	Number of Days from Date of Initial Pathological Diagnosis to Date of Birth	_____ days	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 birth. <a href="#">3008233</a>
iii	Number of Days from Date of Initial Pathological Diagnosis to Date of Last Contact	_____ days	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 last contact. <a href="#">3008273</a>
iv	Number of Days from Date of Initial Pathological Diagnosis to Date of Death	_____ days	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 death. <a href="#">3165475</a>
v	Age at Initial Diagnosis	_____ days	Provide the age of the patient in years, at the time the patient was initially pathologically diagnosed with the tumor submitted for TCGA. <a href="#">2006657</a>
vi	Number of Days from Date of Initial Pathologic Diagnosis to <b>Diagnosis</b> of Well Differentiated Liposarcoma	_____ days	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease described on this form to the date the patient was diagnosed with primary well differentiated liposarcoma. <a href="#">3523205</a>
vii	Number of Days from Date of Initial Pathologic Diagnosis to <b>Resection</b> of Well Differentiated Liposarcoma	_____ days	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 resection of well differentiated liposarcoma. <a href="#">3523210</a>
viii	Number of Days from Date of Initial Pathological Diagnosis to Date of New Tumor Event After Initial Treatment	_____ days	Provide the number of days from the date the patient was initially diagnosed pathologically with the disease to the date of new tumor event after initial treatment. <a href="#">3392464</a>

**Enrollment Form**  
**Sarcoma (SARC)**

ix	Number of Days from Date of Initial Pathologic Diagnosis to Date of Additional Surgery for New Tumor Event	_____ days	Provide the number of days from date of initial pathologic diagnosis to date of additional surgery for new tumor event <u>3008335</u>
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\_\_\_\_\_  
Principal Investigator Signature

\_\_\_\_\_  
Date

*I acknowledge that the above information provided by my institution is true and correct and has been quality controlled.*