AHOD03P1 Request for Diagnostic Review

COG #_______________ Patient Initials ______, _______
Last First

Institution Name ____

Please check the appropriate line below:

_______ Institutional assessment is CR after 3 cycles of chemotherapy. Confirmation required by QARC prior to treatment assignment of no IFRT.

OR

_______ Institutional assessment is TR after resection. Confirmation required by QARC prior to treatment assignment of observation per protocol.

OR

_______ Independent review of the enclosed imaging study or studies is requested. Please note your questions or concerns in the space below.

If not submitted previously, the following items should also be included:

- Radiology reports
- Pertinent clinical information
- Staging and Response Worksheet(s)
- AHOD03P1 Data/Films Checklist

Requestor's name____________________ Date_______________ Best way to contact you after the review:
Phone #________________

Email __________________

Please note the address for QARC: Suite 201, 640 George Washington Highway, Lincoln, RI 02865-4207

16 August 2010