AHOD0431 Request for Diagnostic Review

COG #________________ Patient Initials ______, _______
Last First

Institution Name ____

Please check the appropriate line below:

_______ Institutional assessment is CR/PR/<PR after 3 cycles of chemotherapy. Confirmation of response is required by QARC prior to patients either beginning follow-up (CR confirmed) or the start of IFRT (PR confirmed). Patients with a confirmed <PR response will not continue on protocol therapy.

OR

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

The following items should also be included:

- Radiology reports
- Pertinent clinical information
- Staging and Response Worksheet(s)
- AHOD0431 Data/Films Checklist

Requestor's name_____________________ Date________________ Best way to contact you after the review:
Phone #_________________

Email ___________________