

ACNS0334 DATA/FILMS CHECKLIST

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COG #: _____

RADIOTHERAPY DATA:

(No On-Treatment review is required. Within one week of radiotherapy completion, the following shall be submitted.)

- _____ RT-2 Radiotherapy Total Dose Record Form
- _____ Copy of completed daily RT treatment chart including prescription and daily and cumulative doses to all target volumes and critical organs

If patient will not receive RT, check here: _____

***DIAGNOSTIC IMAGING & REPORTS:**

(Copies of diagnostic imaging is for central review only – not required for RT review)

<p>PreOp (1st surgery): _____ Cranial MR with report _____ Spinal MR with report</p> <p>PostOp (1st surgery): _____ Cranial MR with report _____ Spinal MR with report</p> <p>Post Induction: _____ Cranial MR with report _____ Spinal MR with report</p> <p>Post Consolidation: _____ Cranial MR with report _____ Spinal MR with report</p>	<p>PreOp (2nd surgery): _____ Cranial MR with report _____ Spinal MR with report</p> <p>PostOp (2nd surgery): _____ Cranial MR with report _____ Spinal MR with report</p> <p>Best Response (If patient relapsed/progressed during therapy): _____ Cranial MR with report _____ Spinal MR with report</p> <p>Relapse/Progression: _____ Cranial MR with report _____ Spinal MR with report</p>
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***If any of these items are not available or were not done, please make a notation.**

If patient went off study, please fill in off study date and reason here:

Date: _____ Reason: _____

- MAIL ALL DATA TO: QARC
 Suite 201
 640 George Washington Highway
 Lincoln, RI 02865
- (If you need verification of receipt of this data, please write your name & email address below)
