

Patient Initials: _____

Registration #: _____

Central Review: *All materials to be submitted for real time response reviews. Please note if any of the items are not available.*

**Submission of diagnostic imaging data in digital format is preferred over hard copies of films. Digital files must be in DICOM format, and may be burned onto a CD and mailed to QARC. Multiple studies for the same patient may be submitted on one CD; however, please submit data for only one patient per CD.*

PreStudy

- _____ CXR with report
- _____ NCAP CT with report
- _____ PET/Gallium scan with report
- _____ Bone scan with report (if performed)

Post 2 cycles End of Therapy Relapse

- | | | |
|-------|-------|--|
| _____ | _____ | _____ CXR with report (if positive at study entry) |
| _____ | _____ | _____ Neck CT with report (if positive at study entry) |
| _____ | _____ | _____ CAP CT with report |
| _____ | _____ | _____ PET/Gallium scan with report |
| _____ | _____ | _____ Bone scan with report (if positive at study entry) |

Please submit data to: Quality Assurance Review Center
 AHOD0521 Study
 640 George Washington Highway, Suite 201
 Lincoln, RI 02865-4207
 Phone: (401) 753-7600 Fax: (401) 753-7601
 Email: KKarolczuk@qarc.org

Results of response reviews will be posted on COG website as soon as available.
 If you need verification of receipt of data, please write your name and email address below:
