

ANBL02P1 DATA/FILMS CHECKLIST

QARC Contact: Dee Logan

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Patient Identifier: _____

Registration #: _____

Radiation therapy for patients on COG protocols can only be delivered at approved COG RT facilities (see Administrative Policy 3.9, April 2004). Contact QARC for questions or further information.

RADIOTHERAPY DATA:

(This is a simple (limited) review study. No on-treatment review is required. No RT film submission required. The following shall be submitted:)

_____ RT-2 Form

_____ Daily RT treatment chart (including prescription, daily and cumulative doses)

DIAGNOSTIC IMAGING & REPORTS:

(Copies of diagnostic imaging is for central review only)

_____ Pre-Treatment CT or MRI

_____ Post 2 Cycles CT or MRI

_____ Pre-Op CT or MRI (performed prior to delayed resection after induction cycle #5)

_____ Post-Op CT or MRI (4-6 wks following resection, pre-transplant)

_____ MIBG scans done at:

_____ Pre-Treatment

_____ Pre-Transplant

_____ Copies of all corresponding radiology reports

- MAIL ALL DATA & FILMS TO: (If you need verification of receipt of this data, please write your name & address)

QARC
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640 George Washington Highway
Lincoln, RI 02865-4207