Registration Header *(Information in this box below may be pre-printed by some groups.)*

Coordinating Group Protocol No. _____ Coordinating Group Code _____
Protocol Title _____
_____
Patient Study ID _____ Participating Group Code_____
Patient Medical Record Number _____ Other Patient ID _____
Institution / Affiliate_____ Physician of Record_____

Protocol Administration

IRB/REB Approval Date ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)
Date Informed Consent Signed ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)
Projected Start Date of Treatment ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)
Date of Registration ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)

Person Completing Form, Last Name _____
Person Completing Form, First Name _____
Person Completing Form, Phone (____) _____
Person Completing Form, Fax (____) _____

Patient Demographics / Pre-Treatment Characteristics

Patient Name *(initials acceptable)* _____

Patient Birth Date ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY) Patient Gender ☐ *Male* ☐ *Female*

Patient Race *(check all that apply)* *(U.S. and Canada only)*
☐ *White* ☐ *Black or African American* ☐ *Asian* ☐ *Native Hawaiian or other Pacific Islander* ☐ *American Indian or Alaska Native* ☐ *Unknown*

Patient Ethnicity *(U.S. and Canada only)* ☐ *Hispanic or Latino* ☐ *Not Hispanic or Latino* ☐ *Unknown*

Patient Social Security Number *(USA only)* ☐☐☐ ☐☐ ☐☐☐☐

Patient ZIP Code *(USA)* _____ Country of Residence *(if not USA)* _____

Patient Height *(cm)* ☐☐☐ Patient Weight *(kg)* ☐☐☐.☐ Body Surface Area *(m^2)* ☐.☐☐

Performance Status ***(check one)***
- ☐ *0 = Fully active, able to carry on all pre-disease performance without restriction (Karnofsky 90 - 100)*
- ☐ *1 = Restricted in physically strenuous activity but ambulatory (K 70 - 80)*
- ☐ *2 = Ambulatory and capable of all selfcare but unable to carry out any work activities (K 50 - 60)*
- ☐ *3 = Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours (K 30 - 40)*
- ☐ *4 = Completely disabled (K 10 - 20)*

Method of Payment ***(check one)*** *(USA only)*
☐ *Private Insurance* ☐ *Medicare* ☐ *Medicaid* ☐ *Medicaid and Medicare* ☐ *Medicare and Private Insurance* ☐ *Military or Veterans Sponsored NOS* ☐ *Military Sponsored (including CHAMPUS & TRICARE)* ☐ *Veterans Sponsored* ☐ *Self pay (no insurance)* ☐ *No means of payment (no insurance)* ☐ *Other* ☐ *Unknown*

Certification of Eligibility *(This section may be linked to a separate eligibility checklist at a group's discretion; it is provided to indicate that the investigator has reviewed all eligibility criteria.)*

In the opinion of the investigator, is the patient eligible?

☐ *Yes* ☐ *No*

(if No, the patient should not be registered)

Protocol Design

Stratification Factors *(protocol specific)* _____
_____
_____
Assigned Treatment Arm *(protocol specific)*_____
_____
_____

Initial Patient Consent for Specimen Use *(Optional – for specimen banking studies only)*

Patient's Initial Consent given for specimen use for research on the patient's cancer?	☐ *Yes*	☐ *No*
Patient's Initial Consent given for specimen use for research unrelated to the patient's cancer?	☐ *Yes*	☐ *No*
Patient's Initial Consent given for further contact regarding specimen?	☐ *Yes*	☐ *No*

Date of Consent for Specimen Use ☐☐ ☐☐ ☐☐☐☐
MM DD YYYY