NATIONAL CANCER INSTITUTE

NCI/CTEP SECONDARY AML/MDS REPORT FORM

INSTRUCTIONS: Submit this form to CTEP/NCI **within 30 days** of AML/MDS diagnosis following treatment for cancer on NCI-sponsored trials. The form should be completed for the most recent NCI-sponsored trial on which the patient received treatment. Submit with this form a copy of the **pathology report** confirming the AML/MDS diagnosis and a copy of the **cytogenetic report** (if available). *See reverse side for mailing address.*

PLEASE ANSWER ALL QUESTIONS.

I. PATIENT IDENTIFICATION AND CHARACTERISTICS (Complete all that apply)

Patient ID# (Group): _____
Patient ID# (Coordinating Group)*: _____
Date of Birth (*mo/day/yr*): _____
Gender (*please check*): ☐ Male ☐ Female
Initial Diagnosis: _____

NCI Protocol #: _____
Cooperative Group Name & Protocol #: _____
Coordinating Group Name & Protocol #: _____
Treatment Arm: _____

*For intergroup studies only.

II. AML/MDS DIAGNOSIS AND CHARACTERIZATION

Date of AML/MDS diagnosis (*mo/day/yr*): _____

AML subtype (*please check*): ☐ M1 ☐ M2 ☐ M3 ☐ M4 ☐ M5 ☐ M6 ☐ M7
☐ MDS ☐ Unknown ☐ Other (*specify*): _____

Cytogenetics performed? ☐ No ☐ Yes; please check all that apply:
- ☐ 11q23 abnormality
- ☐ Chromosome 5 and/or 7 abnormality
- ☐ Other chromosome abnormality
  (*specify*): _____
- ☐ Normal

Is cryopreserved marrow specimen available for biology studies? ☐ No ☐ Yes

III. CHEMOTHERAPY FROM LAST/CURRENT NCI-SPONSORED PROTOCOL PRIOR TO AML DIAGNOSIS (*i.e., therapy for protocol listed in Section I.*)

First Day Protocol Chemotherapy Taken (*mo/day/yr*): _____
Last Day Protocol Chemotherapy Taken (*mo/day/yr*) : _____

Agent Received	Actual Cumulative Dose Received (mg/m^2)

Received RT? ☐ No ☐ Yes; please specify:
Site: _____
Total Dose: _____

Received growth factor? ☐ No ☐ Yes; please check all that apply:
☐ G-CSF ☐ GM-CSF ☐ Other (*specify*):

IV. CANCER THERAPY RECEIVED *PRIOR* TO LAST/CURRENT NCI SPONSORED PROTOCOL

Did the patient receive any cancer therapy (*protocol or non-protocol*) prior to last/current NCI protocol therapy (*i.e., protocol listed in Section III*)?

☐ No; if No, go to *Section V*. ☐ Yes

Identify agents/modalities given prior to the NCI sponsored protocol therapy listed in Section III (*check those which apply*).

☐ Alkylators ☐ Epipodophyllotoxins ☐ Platinum ☐ Anthracyclines

☐ Other cytotoxic drugs

☐ RT; if checked, please specify:

Site: _____

Total Dose: _____

Was any of this prior therapy on an NCI-sponsored trial?

☐ No ☐ Yes; please list:

NCI (Group) protocol #: _____

Treatment arm: _____

V. CANCER THERAPY RECEIVED *SUBSEQUENT* TO LAST/CURRENT NCI SPONSORED PROTOCOL

Did the patient receive any cancer therapy prior to the AML/MDS diagnosis, but after completing the NCI sponsored protocol therapy described in Section III?

☐ No; if No, go to *Section VI*. ☐ Yes

Identify agents/modalities given subsequent to the NCI sponsored protocol therapy listed in Section III, but preceding the AML/MDS diagnosis (*check those which apply*).

☐ Alkylators ☐ Epipodophyllotoxins ☐ Platinum ☐ Anthracyclines

☐ Other cytotoxic drugs

☐ RT; if checked, specify:

Site: _____

Total Dose: _____

VI. INVESTIGATOR RESPONSIBLE FOR COMPLETING REPORT

Investigator Name (*please print*): _____

Phone: ( ) _____ Fax: ( ) _____

Institution: _____

Address: _____

Investigator Signature: _____ Date: _____

Submit this form instead of a Form FDA #3500 (MedWatch) for cases of secondary AML/MDS. The **FAX #** for submission of the form **(including the pathology and cytogenetic reports)** to NCI/CTEP is **(301) 230-0159.** Because of the poor quality of some FAX transmissions, please send a hard copy of all AML/MDS reports to the mailing address given below:

Investigational Drug Branch (NCI/CTEP)
PO Box 30012
Bethesda, Maryland 20824

IMPORTANT: Cryopreserved leukemia cells are an invaluable resource. Contact your Cooperative Group Operations Office for information about how leukemia cell specimens should be collected, preserved, and submitted for biology studies.