

NORTH CENTRAL CANCER TREATMENT GROUP  
and MAYO CLINIC

Eligibility Checklist  
(Prospective)

2/2/2007  
Page 1 of 2

NCCTG and Mayo 94-72-52: **Diagnostic and Prognostic Markers in High-Grade Glioma**

Has the patient ever been on a prior study entered through this Randomization Center?  X  Yes

Protocol number \_\_\_\_\_

Patient Study ID number \_\_\_\_\_ Registration Date (Date On) (mm/dd/yyyy) \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

NCCTG Member (Participant Sponsor) \_\_\_\_\_

NCCTG Treating Location \_\_\_\_\_

NCCTG Treating Physician \_\_\_\_\_

Institution patient number (Local Subject number) \_\_\_\_\_

IRB approval date (mm/dd/yyyy) \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_

Patient Initials (*last, first, middle*) \_\_\_\_\_  
(For Mayo-Rochester patients: include first four letters of last name)

Zip code \_\_\_\_\_

Country \_\_\_\_\_

- Method of Payment (*check one*) \_\_\_\_\_
- \_\_\_\_\_ PI (*Private*)
  - \_\_\_\_\_ MR (*Medicare*)
  - \_\_\_\_\_ MRP (*Medicare/Private*)
  - \_\_\_\_\_ MD (*Medicaid*)
  - \_\_\_\_\_ MM (*Medicaid and Medicare*)
  - \_\_\_\_\_ MVA (*Military or Veterans Sponsored NOS*)
  - \_\_\_\_\_ MS (*Military Sponsored [including CHAMPUS & TRCARE]*)
  - \_\_\_\_\_ MV (*Veterans Sponsored*)
  - \_\_\_\_\_ SP (*Self pay [no insurance]*)
  - \_\_\_\_\_ NP (*No means of payment [no insurance]*)
  - \_\_\_\_\_ OTH (*Other*)
  - \_\_\_\_\_ UNK (*Unknown*)

NCCTG and Mayo Prospective Eligibility Checklist 94-72-52

2/2/2007  
Page 2 of 2

Study reg. number \_\_\_\_\_

Eligibility Check - Answer questions below (yes/no). All requirements must be confirmed. All dates are to be M/D/Y.

Yes No

\_\_\_\_ \_\_\_\_ Paraffin-embedded tumor tissue blocks or 15 unstained slides of patients enrolled in the Mayo/NCCTG clinical trials, conducted since 1979, which were designed to assess specific therapies in patients with newly diagnosed high-grade glioma.

**All responses in above section must be "Yes".**

Registration Check - Answer questions below (yes/no). All requirements must be confirmed. All dates are to be M/D/Y.

Yes No

\_\_\_\_ \_\_\_\_ Consent form signed and dated (discretion of each institutional review board).

Date of consent \_\_\_\_-\_\_\_\_-\_\_\_\_.

**Is this a USA institution?** (This question may be answered yes or no.)

\_\_\_\_ Yes → Complete authorization question below.

\_\_\_\_ No → Check "not applicable (**Non-USA institution only**)" and go to next question.

\_\_\_\_ \_\_\_\_ Authorization for use and disclosure of protected health information signed and dated.

Date of authorization \_\_\_\_-\_\_\_\_-\_\_\_\_ vs. not applicable (**Non-USA institution only**) \_\_\_\_.

**All responses in above section must be "Yes".**

Assigned Treatment

\_\_\_\_ 0) Block study + Peripheral blood

Person registering \_\_\_\_\_ Random. specialist \_\_\_\_\_  
Signature initials

Physician \_\_\_\_\_  
Signature M D Y