

Forms Packet

March 26, 2010

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

Contents: Eligibility checklist for retrospective studies (6/29/99)
 Eligibility checklist for prospective studies (2/2/07)
 NIH/CTEP approved codes for patient race/ethnicity/method of payment
 (5/13/99)
 ✓ Biospecimen accessioning processing fax supply order form

✓ designates revised/new forms

NCCTG Retrospective Eligibility Checklist 94-72-52

6/29/99
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 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".

____ ____ Patient eligible.

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 ____-____-____.

Assigned Treatment

____ 0) Block study

Person registering _____ Random. specialist _____
Signature initials

Physician _____ M D Y
Signature

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? 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
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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

Biospecimen Accessioning Processing
Fax Supply Order Form – No Cover Sheet Necessary
Fax to Research Kit Building @ 507-538-4103

NOTE: Form must be either typed or printed legibly and filled out completely.

Study ID: 94-72-52

Investigator: _____

Order Placed By: _____ Phone #: () _____

Email: _____ Fax #: () _____

Complete Address (kits sent to):

ALLOW AT LEAST TWO WEEKS TO RECEIVE THE KITS.

NOTE: Kits will be sent via FedEx® Ground at no additional cost to the participating institutions. Kits will not be sent via rush delivery service unless the participating institution provides their own FedEx® account number or alternate billing number for express service. **The study will not cover the cost for rush delivery of kits.**

Date Needed: _____
(Please be specific)

Fed Ex account number (Rush deliveries only) _____

<u>Type of Kits</u>	<u># of Kits Needed</u>
947252 Research Blood Kit (NCCTG)	_____
_____	_____
	Total Kits _____

Questions? Contact the Biospecimen Resource Manager listed on the Protocol Resource page of the protocol.