

Pre-Registration Eligibility Checklist
 Open to Mayo Rochester, Jacksonville, Scottsdale, and University of Alabama at Birmingham only

N027D: A Phase I Study of CCI-779 and Temozolomide in Combination with Radiation Therapy in Glioblastoma Multiforme

Prior to checking eligibility and pre-registering a patient, contact the Registration Office (507/284-4130) for study status and dose level for Arm A or to ensure a place on the protocol for patients on Arm B.

To register a patient, call (507/284-4130) or fax (507/284-0885) a completed eligibility checklist to the Registration Office between 8 a.m. and 4:30 p.m. central time Monday through Friday.

Has the patient ever been on a prior study entered through this Registration Office? Yes No

If yes: Prior study number _____; prior patient study ID number _____

Registration date (date on) (mm/dd/yyyy) ___/___/_____
Patient study ID number (provided at time of Pre-Reg) _____
NCCTG member (participant sponsor) _____
NCCTG treating location (chemo) _____
(RT) _____
NCCTG treating physician (chemo) _____
(RT) _____
Institution patient number (local subject number) _____
IRB approval date (chemo) (mm/dd/yyyy) ___/___/_____ IRB approval date (RT) (mm/dd/yyyy) ___/___/_____

Patient initials (last, first, middle) _____ (For Mayo Rochester patients, include first four letters of last name.)	Race (check all that apply)
Gender (check one) <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	<input type="checkbox"/> White
Date of birth (mm/dd/yyyy) ___/___/_____	<input type="checkbox"/> Black or African American
Zip code _____	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander
Country of Residence _____	<input type="checkbox"/> Asian
Method of payment (check one)	<input type="checkbox"/> American Indian or Alaska Native
<input type="checkbox"/> PI (Private Insurance)	<input type="checkbox"/> Not reported: Patient refused or not available
<input type="checkbox"/> MR (Medicare)	<input type="checkbox"/> Unknown: Patient unsure
<input type="checkbox"/> MRP (Medicare and Private Insurance)	Ethnicity (check one)
<input type="checkbox"/> MD (Medicaid)	<input type="checkbox"/> Not Hispanic or Latino
<input type="checkbox"/> MM (Medicaid and Medicare)	<input type="checkbox"/> Hispanic or Latino
<input type="checkbox"/> MVA (Military or Veterans Sponsored, Not Otherwise Specified (NOS))	<input type="checkbox"/> Not reported: Refused or data not available
<input type="checkbox"/> MS (Military Sponsored [including CHAMPUS & TRCARE])	<input type="checkbox"/> Unknown: Unsure of their ethnicity
<input type="checkbox"/> MV (Veterans Sponsored)	
<input type="checkbox"/> SP (Self pay [no insurance])	
<input type="checkbox"/> NP (No means of payment [no insurance])	
<input type="checkbox"/> OTH (Other)	
<input type="checkbox"/> UNK (Unknown)	

Addendum 4 dated September 5, 2008 IRB approved?
 Yes. If Yes, Addendum 4 approval date (mm/dd/yyyy) ___/___/_____ No. If No, End form, Addendum 4 IRB approval required.

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Patient study ID number _____

Eligibility Check - Answer questions below (yes/no). All requirements must be confirmed. All dates are to be *mm/dd/yyyy*.

Required Characteristics

Yes No NA

Central pathology review submission. This review is mandatory prior to registration to confirm eligibility. It should be initiated as soon after surgery as possible.	____
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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 *mm/dd/yyyy*.

Yes No NA

Consent form signed and dated. Date of consent __ __/__ __/____.	____
Authorization for use and disclosure of protected health information signed and dated.	____
Non-USA institution only (<i>check NA</i>) vs. Date of authorization __ __/__ __/____.	____
The site has reviewed and understands the process listed in Section 17.0 and must account for sufficient time to complete pre-registration and registration steps.	____

All responses in above section must be “Yes” unless specified as “NA.”

Assigned Treatment

_____ Pre-Registration

Person registering _____ Signature Registration Office specialist _____ initials

Physician _____ Signature M D Y