

NORTH CENTRAL CANCER TREATMENT GROUP

Pre-Registration (Step 1) Eligibility Checklist

11/06/2009

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N0572: **A Pilot and Phase II Trial of Sorafenib and CCI-779 in Patients with Recurrent Glioblastoma**

To pre-register a patient, call (507/284-4130) or fax (507/284-0885) a completed (Step 1) pre-registration 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 Reg/Random) _____

NCCTG member (participant sponsor) _____

NCCTG treating location _____

NCCTG treating physician _____

Institution patient number (local subject number) _____

IRB approval date (mm/dd/yyyy) __/__/____

Person Completing Form:

Last Name: **(print)** _____ First Name: **(print)** _____

Phone: _____ Fax: _____ Email: _____

Patient initials (last, first, middle) _____
(For Mayo Rochester patients, include first four letters of last name.)

Gender (check one) Male Female Unknown

Date of birth (mm/dd/yyyy) __/__/____

Zip code _____

Country of Residence _____

Race (check all that apply)

- White
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Asian
- American Indian or Alaska Native
- Not reported: Patient refused or not available
- Unknown: Patient unsure

Method of payment (check one)

- PI (Private Insurance)
- MR (Medicare)
- MRP (Medicare and Private Insurance)
- MD (Medicaid)
- MM (Medicaid and Medicare)
- MVA (Military or Veterans Sponsored,
Not Otherwise Specified (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)

Ethnicity (check one)

- Not Hispanic or Latino
- Hispanic or Latino
- Not reported: Refused or data not available
- Unknown: Unsure of their ethnicity

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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 M/D/Y.

Yes No

Required Characteristic

____ Central pathology review submission. This review is mandatory prior to registration to confirm eligibility.

It should be initiated as soon after surgery as possible.

Response 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. 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**) ____.

____ 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.”

Assigned Treatment

____ Pre-registration

Person registering Signature _____ Registration Office specialist Initials _____

Physician Signature _____ Date (mm/dd/yyyy) ____/____/____