

NORTH CENTRAL CANCER TREATMENT GROUP
Pre-Registration (Step 1) Eligibility Checklist

02/05/2010
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N0776: Phase II Trial of Avastin® in Combination with Sorafenib in Recurrent Glioblastoma Multiforme

To register a patient, access the NCCTG web page at <https://ncctg.mayo.edu/training> and enter the remote registration/randomization application.

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) _____

Gender (check one) Male Female Unknown

Date of birth (mm/dd/yyyy) ___/___/_____

Zip code _____

Country of Residence _____

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)

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

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 *mm/dd/yyyy*.

Inclusion Criteria

Yes No NA

| | | | |
|--|-------|-------|-------|
| Central pathology review submission. This review is mandatory prior to registration to confirm eligibility (see Section 17.2). It should be initiated as soon as possible after pre-registration. | _____ | _____ | _____ |
|--|-------|-------|-------|

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 informed consent signed __ __/__ __/____ | _____ | _____ | _____ |
| Authorization for use and disclosure of protected health information signed and dated (<i>U.S.A. institutions only</i>). If not a USA institution (<i>check NA</i>); If a USA institution - 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.”

Person registering Signature _____ Registration Office specialist initials _____

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