N0779: **Phase II Study of Vorinostat (SAHA) in Combination with Bortezomib (PS-341) in Patients with Recurrent Glioblastoma Multiforme**

To pre-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 _____________________

Pre-Registration date (date on) *(mm/dd/yyyy)* __ __/__ __/__ __ __ __

Patient study ID number *(provided at time of Pre-Registration)* ____________________

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

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**.	____ ____

Response in above section must be "Yes."

Pre-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. If not a USA institution *(check NA)*; If a USA institution - Date of authorization __ __/__ __/__ __ __ __	____ ____ ____
The site has reviewed and understands the process listed in Section 17.2 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 ________________________________ Registration Office specialist _______
Signature initials

Physician ____ _____-_____-_____
Signature mm dd yyyy