Cancer in Young People in Canada (CYP-C) Data Collection Forms March 2023

Registration Elements Highlighted

1.0 Registration

Patient Demographics
[This section should be completed only once per patient, but should be updated if new information known (i.e. name change, etc)].

1.1 MRN: _____

1.2 Last name: _____

1.3 Middle name: _____

1.4 First name: _____

1.5 Sex: □ Male □ Female □ Unknown

1.6 Birth date: _____/_____/_____
(dd /MON/yyyy)

1.7 Age at diagnosis: ___[Prepopulated]_____

1.8 Address: _____

1.9 City: _____

1.10 Province of residence at time of diagnosis:

□British Columbia
□Alberta
□Saskatchewan
□Manitoba
□Ontario
□Quebec
□New Brunswick
□Nova Scotia
□Prince Edward Island
□Newfoundland & Labrador
□Yukon
□Northwest Territories
□Nunavut

1.11 Postal code of residence at diagnosis: _____

1.12 Provincial Health Insurance Number: _____

1.13 To which race(s) does the patient belong? *(Check all that apply)*

□ Indigenous:
- □ First Nations
- □ Métis
- □ Inuit
- □ Indigenous, not otherwise specified

□ Middle Eastern (e.g. Arab, Lebanese, Arab-Israeli, Palestinian, Jordanian, Iranian, Afghani, Armenian, Turkish, includes ethnic Arab from Morocco, Egypt, Libya, Algeria and Tunisia, etc)

□ East/Southeast Asian:
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Southeast Asian (e.g. Vietnamese, Cambodian, Malaysian, Laotian, Thai, etc)

□ South Asian (e.g. East Indian, Pakistani, Bangladeshi, Sri Lankan, Bhutanese, Nepalese)

□ Black (e.g. African Canadian, African American, African-Caribbean (e.g. Haitian, Jamaican, Trinidadian), African (e.g. Somali, Nigerian, Angolan, Gambian) (excluding ethnic Arab from Morocco, Egypt, Libya, Algeria and Tunisia))

□ Latino (Hispanic, Latin American descent, South American (eg. Brazilian, Chilean, Peruvian), Spanish, Portuguese, Mexican, Hispanic Caribbean (Cuban, Porto Rican))

□ White (e.g. Caucasian, White-European Ancestry, see Data Manual for examples)

□Other, specify: _____
□ Not available

1.14 Limited Registry

1.14.1 Canadian Resident:
- □ Yes
- □ No

1.14.2 Diagnosis and/or treatment status in a CYP-C center:
- □ Complete
- □ Partial (diagnosis and/or initial treatment outside of Canada)

1.15 PROFYLE ID: _____

1.16 POGONIS ID: _____

2.0 Diagnostic Information

2.1 Time to Treatment

(This section is required for each new primary tumour; however, it is not required if entering a revised diagnosis).

2.1.1 Date of first health care contact for initial symptoms:

Date: ____/____/_____
(dd/MON/yyyy)

□ **Not available/unknown**
□ **Not applicable**

2.1.2 Date first seen at a CYP-C institution for symptoms that led to diagnosis:

Date: ____/____/_____
(dd/MON/yyyy)

□ **Not available/unknown**

2.1.3 Date first seen by ONCOLOGIST:

Oncologist: Date: ____/____/_____
(dd/MON/yyyy)

□ Not available
□ Not applicable

2.1.3.1 Type of oncologist:

□Pediatric Oncologist/Hematologist
□Medical Oncologist/Hematologist
□Radiation Oncologist
□Gynecologic Oncologist
□Surgical Oncologist
□Not available

2.1.4 Date first seen by SURGEON:

If surgical oncologist selected above (2.1.3), do not count their visit here.

Surgeon: **Date:** ____/____/_____
(dd/MON/yyyy)

□ Not available/unknown
□ Not applicable

2.2 Diagnostic Record

2.2.1 Specify ordinal primary: _____

1= 1st primary (first cancer diagnosis – no prior cancer(s))
2= 2nd primary (2nd cancer diagnosis – one prior cancer)
3= 3rd primary (3rd cancer diagnosis – two prior cancers)
4= 4th primary (4th cancer diagnosis – three prior cancers)

2.2.2 Is this the initial report or a revised diagnosis?

□ Initial report
□ Revised diagnosis → *If a revised diagnosis, please update sections 2.2 to 2.5.*

2.2.3 Date of definitive diagnostic procedure:
(Procedure which determined the treatment plan – see manual in regards to non-microscopic diagnosis dates.)
Note: revised diagnosis date may be after treatment initiated. Use date revised diagnosis is made.

Date: _____/____/_____
(dd/MON/yyyy)

2.2.4 Definitive diagnosis based on:

□ Histology
□ Radiology
□ EUA (Examination under Anesthesia)
□ Tumour Marker (such as AFP and βhCG)
□ Other, specify: _____
□ Not available

2.2.5 Institution of diagnosis:

□B.C. Children's Hospital
□Alberta Children's Hospital
□Stollery Children's Hospital
□Saskatoon Cancer Centre
□Allan Blair Cancer Centre
□CancerCare Manitoba
□Children's Hospital, LHSC / Children's Hospital of Western Ontario
□McMaster Children's Hospital
□The Hospital for Sick Children
□Kingston General Hospital
□Children's Hospital of Eastern Ontario
□Centre Hospitalier Universitaire Sainte Justine
□Montreal Children's Hospital
□Centre Hospitalier Universitaire de Sherbrooke
□Centre Hospitalier Universitaire de Québec
□Izaak Walton Killam Health Centre
□Janeway Children's Health & Rehabilitation Centre
□Children's Hospital of Winnipeg
□Other, specify: _____
□Not available

2.2.6 ICDO M code: _____/___ **2.2.7 ICDO T code:** C_____.___

Paper CRFs only (will be pre-populated by M& T codes in the electronic system)

2.2.8 Diagnosis description (morphology/histology):
*(*e.g. Malignant lymphoma, large cell, diffuse*)*

_____
_____
_____

2.2.9 Site of tumor: _____

2.3 Stage

ALL, skip to 2.4.7 *AML, skip to 2.4.8* *CML, skip to 2.4.9* *MDS, skip to 2.4.10*

2.3.1 Staging system (2.3.1a) and Stage (2.3.1b) used by cancer type:

2.3.1.1 Hodgkin Lymphoma (ICCC IIa)

☐ Ann Arbor ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐A ☐B
☐ Not Available

2.3.1.2 Non-Hodgkin Lymphoma (ICCC IIb)

☐ Murphy/St. Jude ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Not Available

2.3.1.3 CNS Tumours (ICCC IIIa and IIIc)

☐ Chang ☐ M0 ☐ M1 ☐ M2 ☐ M3 M4
☐ Not Available

2.3.1.4 Neuroblastoma and other peripheral nervous cell tumours (ICCC IVa)

☐ INSS ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 4S
☐ INRG ☐ L1 ☐ L2 ☐ M ☐ MS
☐ Not Available

2.3.1.5 Retinoblastoma (ICCC V) International Classification for Intraocular Retinoblastoma

☐ Stage left ☐ A ☐ B ☐ C ☐ D ☐ E ☐ Not Applicable
☐ Stage right ☐ A ☐ B ☐ C ☐ D ☐ E ☐ Not Applicable
☐ Not Available

2.3.1.6 Wilm's Tumour (ICCC VIa)

☐ NWTSG ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
☐ Not Available

2.3.1.7 Hepatoblastoma (ICCC VIIa)

☐ Pretext (pre-surgical only) ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Not Available

2.3.1.8 Rhabdomyosarcoma (ICCC IXa)

☐ IRSG
Group ☐ I ☐ II ☐ III ☐ IV
Stage ☐ 1 ☐ 2 ☐ 3 ☐ 4
☐ Not Available

2.3.1.9 Specific Tumours Requiring TNM Staging: hepatocellular carcinoma, gonadal germ cell tumors, thyroid tumors, nasopharyngeal carcinoma and malignant melanomas (ICCC VIIb, Xc, XIb, XIc and XId)

□ TNM	□ T1	□ T2	□ T3	□ T4	□ TX
	□ N0	□ N1	□ N2	□ N3	□ NX

□ Not Available

2.3.2 Select Seer Summary Stage (except ALL, AML, CML or MDS)

- □ Localized
- □ Regional
- □ Distant
- □ Not Applicable
- □ Not Available

2.4 Histology and Other Characteristics

2.4.1 Neuroblastoma and Ganglioneuroblastoma (ICCC IVa)

- □ Shimada favourable
- □ Shimada unfavourable
- □ Not Available

2.4.2 Retinoblastoma (ICCC V)

- □ Unilateral
- □ Bilateral
- □ Trilateral
- □ Not Available

2.4.3 Wilms or Nephroblastoma and other nonepithelial renal tumours (ICCC VIa)

- □ Histology favourable
- □ Histology anaplastic focal
- □ Histology anaplastic diffuse
- □ Not Available

2.4.4 Osteosarcoma (ICCC VIIIa)

- □ Necrosis > 90%
- □ Necrosis ≤ 90%
- □ Necrosis not applicable
- □ Necrosis not known
- □ Not Available

2.4.5 Thyroid Tumours (ICCC XIb)

- □ Histology papillary
- □ Histology medullary
- □ Histology anaplastic
- □ Histology follicular
- □ Histology other/NOS
- □ Not Available

2.4.6 Burkitt Lymphoma (ICCC IIc)

- □ A
- □ B
- □ C
- □ Not Available

2.4.7 Acute Lymphoblastic Leukemia (ALL)

[Note: skip to section 2.5 if NOT leukemia or MDS]

2.4.7.1 Initial white blood cell count:

WBC count:_____ **(*10E^9/L)**

□ Not available

2.4.7.2 What was the disease status of the cerebrospinal fluid at diagnosis?

□ CNS 1
□ CNS 2
□ CNS 3
□ Not available
□ Not tested

2.4.7.3 Was there testicular involvement at diagnosis?

□Yes
□ No
□ Not available
□ Not applicable

2.4.7.4 Minimal Residual Disease (MRD) - Restricted to Bone Marrow Evaluation					
Check if yes	**2.4.7.4.1 Time Point**	**2.4.7.4.2a MRD Value (%)**	**2.4.7.4.3a Date** (dd/MON/yyyy)	**2.4.7.4.2b MRD Value (%)**	**2.4.7.4.3b Date** (dd/MON/yyyy)
☐	End Induction		____/_____/____		____/_____/____
☐	End Consolidation		____/_____/____		____/_____/____
☐	Pre-HSCT		____/_____/____		____/_____/____
☐	Other: _____		____/_____/____		____/_____/____

2.4.7.5 Was immunophenotyping/flow cytometry done at diagnosis?

□ Yes
□ No
□ Not available

2.4.7.5.1 If yes, specify phenotype:

□ pre B-cell (Acute Lymphoblastic Leukemia, pre-B type)
□ B-cell (Burkitt's Leukemia)
□ T-cell
□ Mixed, specify: _____
□ Other, specify: _____
□ Not available

2.4.7.6 Was chromosomal testing done at diagnosis?

□Yes □ No □ Not available

If yes, please check all those that apply:

2.4.7.6a Translocations:

□ t(1;19)(q23;p13) (*TCF3-PBX1*)
□ t(4;11)(q21;q23) *(KMT2A-AF4)*
□ t(5;14)(q31.1;q32.3) (IL3-IGH)
□ t(9;11)(p21;q23) (KMT2A MLLT3)
□ t(8;14)(q24;q32) (*c-MYC-IGH)*
□ t(9;22)(q34;q11) (BCR-ABL1)]
□ t(10;11)(p12;q23) (KMT2A-MLLT10)
□ t(11;19)(q23;p13.3) (*KMT2A-MLLT1*)
□ t(12;21) (*TEL-AML1* cryptic translocation or ETV6-RUNX1)
□ other KMT2A (MLL) (11q23) rearrangement
□ other *MYC* (8q24) rearrangement
□ t(17;19)(q22;p13.3) (TCF3-HLF)
□ Ph-/BCR-ABL1–like

2.4.7.6b Trisomy:

□ Hyperdiploid
□ +4
□ +10

2.4.7.6c Other Recurrent Rearrangements/Karyotypes

□ dic(9;20)(p13;q11.2)
□ Amplified NUP214/ABL1 (9q34)
□ Near haploidy/Hypodiploidy
□ RUNX1 (AML1)(21q22) amplification (iAMP21)

□ **Checked and none of the above chromosomal abnormalities were found**

2.4.8 Acute Myeloid Leukemia (AML)

2.4.8.1 Initial white blood cell count:

WBC count: _____ **(*10E^9/L)** □ **Not available**

2.4.8.2 Was chromosomal testing done at diagnosis?

□ Yes □ No □ Not available

If yes, please check all those that apply:

2.4.8.2a Translocations:

□ t(1;22)(p13;q13) (*OTT-MAL /RBM15-MKL1*)
□ t(1;11)(q21;q23); KMT2A (MLL)- MLLT11
□ t(6;9)(p23;q34) (DEK-NUP214)
□ t(8;16)(p11;p13) *(MOZ / MYST-CREBBP)*
□ t(5;11)(q35.3;p15.5); NUP98-NSD1
□ t(8;21)(q22;q22) *(AML1-ETO)*
□ t(9;11)(p22;q23); MLLT3-MLL
□ t(9;11)(p21;q23) *(KMT2A-MLLT3)*
□ t(6;11)(q27;q23); KMT2A (MLL)-MLLT4□ t(9;22)(q34;q11) (BCR-ABL1)]
□ t(7;12)(q36.3;p13.2); MNX1-ETV6
□ t(10;11)(p12;q14) (PICALM-MLLT10/CALM-AF10)
□ t(10;11)(p12;q23) (KMT2A-MLLT10)
□ t(15;17)(q22;q11-12)
□ t(15;17)(q22;q12~21) (PML/RARα)
□ t(16;16)(p13;q11)
□ t(16;16)(p13;q22) *(CBFB-MYH11)*
□ other KMT2A (*MLL)* (11q23) rearrangement

2.4.8.2b Inversion:

□ inv(3)(q21.3q26.2) or t(3;3)(q21.3;q26.2); GATA2, MECOM
□ inv(16)(p13q22) *(CBFB-MYH11)*
□ inv(16)(p13.3q24.3); CBFA2T3-GLIS2

2.4.8.2c Monosomy:

□ chromosome 5/del(5q)
□ chromosome 7

2.4.8.2d Other:

□ abnormal FLT3 allelic ratio
□ biallelic mutation of CEBPA
□ mutated NPM1
□ mutated RUNX1

□ **Checked and none of the above chromosomal abnormalities were found**

2.4.9 Chronic Myeloid Leukemia (CML)

2.4.9.1 Was chromosomal testing conducted?

Note: If you select Ph+ve CML (9875/3) as the ICDO M Code (2.2.6), this question will not appear on eCYP as the information is already contained in the M code.

□ Yes
□ No
□ Not available

If yes:

2.4.9.1a Translocations:

□ t(9;22)(q34;q11) *(BCR-ABL1)]*; BCR/ABL positive; Philadelphia chromosome (Ph1) positive

□ **Checked and none of the above chromosomal abnormalities were found**

2.4.10 Myelodysplastic Syndrome (MDS)

2.4.10.1 Initial white blood cell count:

WBC count: _____ **(*10E^9/L)**

□ Not available

2.4.10.2 Was chromosomal testing conducted at diagnosis?

□ Yes
□ No
□ Not available

If yes:

2.4.10.2a Monosomy:

□ chromosome 7

□ **Checked and none of the above chromosomal abnormalities were found**

2.4.11 Other Biology/Genetic Tumour Traits

Was chromosomal testing done at diagnosis?

□ Yes □ No □ Not available

2.4.11.1 Gliomas (ICCC IIIb and IIId)

□ BRAFV600E
□ Fusion BRAF-KIAA1549 (del7q34)
□ H3K27M
□ MSH2 deletion/loss/alteration
□ MSH6 deletion/loss/alteration
□ MLH1 deletion/loss/alteration
□ PMS2 deletion/loss/alteration

2.4.11.2 Medulloblastoma (ICCC IIIc)

□ WNT
□ SHH
□ Non-WNT-Non SHH group 3
□ Non-WNT-Non SHH group 4
□ Non-WNT-Non SHH unknown

2.4.11.3 Neuroblastoma (ICCC IVa)

□ MYCN amplified
□ Hyperdiploid

2.4.11.4 Wilms (ICCC VIa)

□ LOH of 1p
□ LOH 16q

2.4.11.5 Ewing Sarcoma (ICCC VIIIc)

□ t(11;22)(q24;q12) (EWSR1/FLI1)
□ Other EWSR1 translocation
□ BCOR-CCNB3 fusion

2.4.11.6 Rhabdomyosarcoma (ICCC IXa)

□ FOXO1 fusion positive

2.4.11.7 Melanoma (ICCC XId)

□ BRAFV600E
□ BRAF alteration other than V600E

□ **Checked and none of the above chromosomal abnormalities were found**

2.5 Extent of Disease at Diagnosis

Includes all types of cancer:
– Leukemia/lymphoma: if CSF is positive and/or testes are involved, please be sure to check off as a metastatic site(s)
– If CNS metastasis: indicate if CSF, spinal cord and/or brain are involved (select all that apply)

2.5.1 Was there metastasis at diagnosis?

☐Yes ☐No ☐Not available

↓

If yes:

2.5.2 Metastatic sites (check all general sites that apply):

☐Abdomen (NOS)	☐Lymph nodes-local/regional
☐Adrenal gland-bilateral	☐Mediastinum
☐Adrenal gland-left/right	☐Meninges
☐Bladder	☐Muscular tissue (NOS)
☐Bone marrow	☐Ovary – left/right
☐Bone-multiple	☐Ovary - bilateral
☐Bone-single	☐Pancreas
☐Brain	☐Pelvis/Inguinal region (NOS)
☐Breast	☐Peritoneal
☐Cerebrospinal fluid (CSF)	☐Pituitary gland
☐Eye-bilateral	☐Pleura
☐Eye-left/right	☐Skin
☐Head and neck (NOS)	☐Small bowel
☐Heart	☐Spinal cord
☐Kidney-bilateral	☐Spleen
☐Kidney-left/right	☐Testes – left/right
☐Large bowel	☐Testes – bilateral
☐Liver	☐Thyroid
☐Lung-bilateral	☐Uterus
☐Lung-left/right	☐Other, specify:_____
☐Lymph nodes-distant	☐Not available

2.6 Organ Transplantation

2.6.1 Did the patient previously receive an organ or hematopoietic cell transplant prior to malignancy?

- Yes
- No
- Not available

If yes:

2.6.2 Date transplant was received:

Date: _____
(dd/MON/yyyy)

2.6.3 Type of transplant received:

- Heart
- Hematopoietic cells
- Kidney
- Liver
- Lung
- Pancreas
- Other, specify: _____
- Not available

2.7 Predisposing and Genetic Conditions

2.7.1 If patient has an underlying genetic condition, when was the condition diagnosed relative to cancer diagnosis?

- ☐ Before
- ☐ During
- ☐ After

2.7.2 Does the patient have constitutional trisomy 21/Down syndrome or mosaicism for trisomy 21?

- ☐ Yes
- ☐ No

2.7.3 Known Cancer Predisposition Syndrome:

- ☐ Ataxia-telangiectasia
- ☐ Beckwith-Wiedemann or other overgrowth syndromes [other in training binder]
- ☐ Constitutional (biallelic) mismatch repair deficiency syndrome
- ☐ Denys-Drash syndrome
- ☐ DICER1 syndrome
- ☐ Familial adenomatous polyposis
- ☐ Fanconi anemia
- ☐ Frasier syndrome
- ☐ Gorlin syndrome
- ☐ Hereditary pheochromocytoma paraganglioma syndrome
- ☐ Hereditary retinoblastoma syndrome
- ☐ Li-Fraumeni syndrome
- ☐ Multiple endocrine neoplasia type 1
- ☐ Multiple endocrine neoplasia type 2
- ☐ Neurofibromatosis Type 1 (NF1)
- ☐ Neurofibromatosis Type 2 (NF2)
- ☐ Nijmegen breakage syndrome
- ☐ Noonan syndrome
- ☐ Rhabdoid tumour predisposition syndrome
- ☐ Tuberous sclerosis complex
- ☐ Von Hippel-Lindau syndrome
- ☐ WAGR syndrome
- ☐ **No or unknown**

3.0 Patient Contact and Status

(Capture data from diagnosis until 5 years post diagnosis)

Malignancy:_____

3.1 Patient Contact and Status

Year of Follow Up	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**
3.1.2 Start date:	Date of diagnosis	Date of diagnosis + 1 year	Date of diagnosis + 2 years	Date of diagnosis + 3 years	Date of diagnosis + 4 years
3.1.3 End date:	Date of diagnosis + 1 year	Date of diagnosis + 2 years	Date of diagnosis + 3 years	Date of diagnosis + 4 years	Date of diagnosis + 5 years
Was there any contact within period above?*					
Yes	☐	☐	☐	☐	☐
No	☐	☐	☐	☐	☐
3.1.4 If yes, enter date of last contact:					
What was the date of last contact?	___/____/___	___/____/___	___/____/___	___/____/___	___/____/___
If no contact, enter details below:*					
Monitor only (no follow-up needed in the time period)	☐	☐	☐	☐	☐
Moved out of country	☐	☐	☐	☐	☐
Patient not seen / no contact	☐	☐	☐	☐	☐

***optional: elements are not in the database**

3.2 Patient Information Summary

Year of Follow Up	**Year 1**		**Year 2**		**Year 3**		**Year 4**		**Year 5**	
3.2.1 Start date:	Date of diagnosis		Date of diagnosis + 1 year		Date of diagnosis + 2 years		Date of diagnosis + 3 years		Date of diagnosis + 4 years	
3.2.2 End date:	Date of diagnosis + 1 year		Date of diagnosis + 2 years		Date of diagnosis + 3 years		Date of diagnosis + 4 years		Date of diagnosis + 5 years	
3.2.3 Section	**Details Entered**	**3.2.4a Date** dd/MON/yyyy	**Details Entered**	**3.2.4b Date** dd/MON/yyyy	**Details Entered**	**3.2.4c Date** dd/MON/yyyy	**Details Entered**	**3.2.4d Date** dd/MON/yyyy	**Details Entered**	**3.2.4e Date** dd/MON/yyyy
Protocol/Treatment plan details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Chemotherapy treatment details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Surgery details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Radiotherapy details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Cellular Therapy details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Hospitalization details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Complications details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Revised diagnosis details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Relapse details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Second or subsequent primary (new malignancy) details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Patient transfer in or transfer out of your centre	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___
Death details	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___	☐ Yes ☐ No	___/___/___

4.0 Height and Weight

Enter height and weight taken at diagnosis and once per year thereafter. If multiple weights in a given year, use the date closest to the anniversary of diagnosis.
Annual height and weight only collected for the first 2 primaries in the event of multiple primaries.

Malignancy:_____

Diagnosis and Anniversary Dates (pre-populated electronically)	**4.1 Date for Height** (dd/MON/yyyy)	**4.2 Height** (cm)	**Not Available**	**4.3 Date for Weight** (dd/MON/yyyy)	**4.4 Weight** (kg)	**Not Available**	**BMI***
___/___/____	___/___/____	_____ cm	☐	___/___/____	_____ kg	☐	
___/___/____	___/___/____	_____ cm	☐	___/___/____	_____ kg	☐	
___/___/____	___/___/____	_____ cm	☐	___/___/____	_____ kg	☐	
___/___/____	___/___/____	_____ cm	☐	___/___/____	_____ kg	☐	
___/___/____	___/___/____	_____ cm	☐	___/___/____	_____ kg	☐	
___/___/____	___/___/____	_____ cm	☐	___/___/____	_____ kg	☐	

* BMI will be computed by program

5.0 Protocol/Treatment Plan Information

(Note: Please fill out a separate page for each protocol/treatment plan)

Treatment Plan #_____

Diagnosis:_____

5.1 Treatment Plan Used:

- □ Registered on a clinical trial protocol
- □ Not registered and following a clinical trial protocol
- □ Not registered and NOT following a clinical trial (includes ITP and SOC)
- □ Observation alone, not on a clinical trial
- □ Not available

5.2 If not registered on a clinical trial, please give reason:

- □ Language barrier, trial not offered
- □ No available trial at the time
- □ Not eligible for any available trial
- □ Physician choice
- □ Refused therapy
- □ Refused to participate in proposed trial
- □ Other, specify: _____
- □ Not available

5.3 Protocol name or number:

_____ □Not applicable

5.4 Treatment arm:_____ □Not applicable

5.5 Date treatment began:

(Note: Use the date systemic chemotherapy began for leukemics, NOT intrathecal.)

Date: _____/_____/_____
(dd/MON/yyyy)

□ Not available

5.6 Protocol/Treatment Plan Status:

□ Completed as planned
□ Terminated early
□ In progress
□ Not applicable (e.g. observation only)

5.7 If protocol/treatment completed OR terminated early, specify date:

Date: _____/_____/_____
(dd/MON/yyyy)

□ Not available

5.8 If protocol/treatment plan terminated early, reason treatment plan not completed

□ Death
□ Physician preference
□ Progression/no response
□ Refusal to continue
□ Relapse
□ Revised diagnosis
□ Other, specify: _____
□ Not available
□ Second malignancy
□ Stem cell transplant
□ Study terminated
□ Study violation
□ Toxicity

□ Use multiple pages as required. Check box if multiple pages used.

6.0 Chemotherapy List

Diagnosis:_____

6.1 Was chemotherapy used?

□ Yes □ No (if no, please skip to section 8.0 surgery details)

6.2 If yes, check all agents that apply:

Includes monoclonal antibodies and Biological Effect Modifiers (eg. G-CSF). Does NOT include chemotherapy used as part of the preparative regimen prior to hematopoietic cell transplant.

Agents highlighted in Grey require the completion of the Chemotherapy Details form

6.2 Chemotherapeutic Agent	Check if administered	Chemotherapy Details Completed
Alemtuzumab, Campath	□	
Amsacrine, Acridinyl anisidide, m-AMSA	□	
Arsenic trioxide (Trisinox)	□	
Asparaginase E-Coli (L-Asp), Elspar, Kidrolase	□	
Asparaginase Erwinia (Erwinase)	□	
Asparaginase Peg	□	
Azacytidine (Aza-C) 5-AZA, 5-AC, 5-azacytidine)	□	
Bevacizumab (Avastin)	□	
Bleomycin, Blenoxane, Bleo*	□	□
Blinatumomab	□	
Bortezomib (Velcade)	□	
Brentuximab vedotin (SGN-35)	□	
Busulphan, Busulfan, (Myleran)*	□	□
Calaspargase pegol (CalPeg and Asparlas)	□	
Carboplatin, CBDCA, Paraplatin, Carboplatinum	□	
Carmustine (BCNU), Bis-Chloroethyl-Nitrosourea, BiCNU*	□	□
Ch14.18 (Dinutuximab)	□	
Cisplatin, CDDP, Platinol, Cisplatinum, Cis-diamminedicloro-platinum II, P*	□	□
Cladribine, CdA, Leustatin	□	

6.2 Chemotherapeutic Agent	Check if administered	Chemotherapy Details Completed
Clofarabine, Clolar	☐	
CPX-351 (liposomal cytarabine and daunorubicin)*	☐	☐
Crizotinib	☐	
Cyclophosphamide, Cytoxan, CTX, Procytox*	☐	☐
Cytarabine, Ara-C, Cytosar, Cytosine arabinoside (IM, sub q, PO OR IV)	☐	
Cytarabine, Ara-C, Cytosar, Cytosine arabinoside (IT ONLY)	☐	
Dabrafenib	☐	
Dacarbazine (DTIC), Dimethyl Trazenoimidazole Carboxamide	☐	
Dactinomycin (DACT), Actinomycin D, Cosmogen, Act-D	☐	
Dasatinib (BMS-354825)	☐	
Daunomycin, Daunorubicin, Cerubidine, DNR*	☐	☐
Dexamethasone (Decadron)	☐	
DMFO (difluoromethylornithine)	☐	
Docetaxel (Taxotere)	☐	
Doxorubicin, Adriamycin, ADR*	☐	☐
Doxorubicin-pegylated liposomal (DOXIL), PLD*	☐	☐
Erlotinib, Tarceva, OSI-774	☐	
Etoposide (VP16), VePesid, ETOP*	☐	☐
Etoposide Phosphate*	☐	☐
Everolimus (Afinitor)	☐	
Fludarabine, FAMP, Fludara	☐	
Fluorouracil (5-FU, Adrucil, Efudex, Fluoroplex, 5-fluorouracil)	☐	
Gemcitabine (Gemzar)	☐	
Gemtuzumab (Mylotarg)	☐	
Hydrocortisone (IT ONLY)	☐	
Hydroxyurea, Hydroxycarbamide, Hydrea	☐	
Idarubicin, Idamycin, 4-Demethoxydaunorubicin*	☐	☐
Ifosfamide, Isophosphamide, IFOS, Ifex, Holoxan*	☐	☐

6.2 Chemotherapeutic Agent	**Check if administered**	**Chemotherapy Details Completed**
Imatinib (Gleevec), IMAT	☐	
Inotuzumab	☐	
Interferon	☐	
Interleukin-2	☐	
Ipilimummab (Yervoy)	☐	
Irinotecan (CPT-11), Camptosar	☐	
Isotretinoin, 13-cis-Retinoic Acid	☐	
Larotrecnitib	☐	
Lenalidomide, Revlimid	☐	
Lomustine (CCNU), CeeNU, Chloroethyl-Cyclohexyl-Nitrosurea*	☐	☐
Melphalan, L-PAM, Alkeran, L-sarcolysin*	☐	☐
Mercaptopurine (6-MP, Purinethol, 6-mercaptopurine)	☐	
Methotrexate, MTX, amethopterin (IM, sub q, PO OR IV <500mg/m^2 per dose)	☐	
Methotrexate, MTX, amethopterin (IT ONLY)	☐	
Methotrexate, MTX, amethopterin* (ONLY IV ≥500mg/m^2 per dose)	☐	☐ (IV ≥500mg/m^2)
Mitotane, Lysodren	☐	
Mitoxantrone, Novantrone, DHAD, Dihydrochloride*	☐	☐
Nelarabine (Arranon, AraG)	☐	
Nilotinib (AMN107, Tasigna)	☐	
Nivolumab	☐	
Oxaliplatin, Eloxatin	☐	
Paclitaxel, Taxol	☐	
Pazopanib	☐	
Pembrolizumab	☐	
Prednisone (Methylprednisone, Prednisolone)	☐	
Procarbazine, PCB, Natulan, Matulane*	☐	☐
Rituximab, Rituxan	☐	
Sirolimus	☐	

6.2 Chemotherapeutic Agent	Check if administered	Chemotherapy Details Completed
Sorafenib, BAY 43-9006, Nexavar	☐	
Sunitinib (Sutent, SU11248)	☐	
Tamoxifen, Tam, Nolvadex	☐	
Temozolomide, TMZ, Temodal	☐	
Temsirolimus (CCI-779)	☐	
Thalidomide (Thalomid)	☐	
Thioguanine (6-TG, Lanvis, 6-thioguanine)	☐	
Thiotepa, TESPA, Triethylene Thiophosphoramide*	☐	☐
Topotecan (Hycamtin)	☐	
Trametinib	☐	
Treosulfan*	☐	☐
Tretinoin, ATRA, all-trans-Retinoic acid, Vesanoid	☐	
Vinblastine, Velbe, Velban, VLB	☐	
Vincristine, Leurocristine, Oncovin, VCR	☐	
Vinorelbine, Navelbine	☐	
Vorinostat	☐	
Other, specify: _____	☐	

7.0 Chemotherapy Details

Complete this information for each agent that the patient received and was grey-shaded on the Chemotherapy List (Section 6.0).

Chemotherapy Details Chart			Diagnosis:______________________________				
7.1 Agent Name (pre-populated electronically)	**7.2 Date Agent First Administered**	**7.3 Date Agent Last Administered**	**7.4 Type of Dose**	**7.5 Dose**	**7.6 Unit of Dose**	**7.7 Route of Administration**	**7.8 Total Dose Current until this date**
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____

7.1 Agent Name (pre-populated electronically)	7.2 Date Agent First Administered	7.3 Date Agent Last Administered	7.4 Type of Dose	7.5 Dose	7.6 Unit of Dose	7.7 Route of Administration	7.8 Total Dose Current until this date
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____
	___/____/____	___/____/____	□ Total dose □ Total dose/kg □ **Total dose/m²**		□ **mg** □ g □ microg □ U □ IU	□ **IV** □ IC □ IM □ IT □ PO □ Sub Q □ N/A □ IA	___/____/____

□ **Check box if multiple pages were used.**

8.0 Surgery Details

Was surgery ever performed?

□ Yes □ No (if no, please skip to section 9.0 Radiation Details)

If yes, enter information for all surgeries *used as a form of treatment*. Check all that apply.

Includes: excisional biopsies.
Excludes: incisional biopsies, bone marrow aspirates, lumbar punctures, or central lines.
Use multiple pages as required.

Diagnosis: _____

CANCER TREATMENT RELATED SURGERY							
Check if yes	**8.1.1 Surgical Sites Involved:**	**8.1.2 Partial or complete TUMOUR resection**	**8.1.3 Extent of ORGAN resection**	**8.1.4 Surgical sites involved laterality**	**8.1.5 Date of Cancer Related Surgery**		
					Date (dd/MON/yyyy)	**Date** (dd/MON/yyyy)	**Date** (dd/MON/yyyy)
□	Abdomen (NOS)	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____
□	Adrenal	□ Partial □ Complete	□ Partial excision □ Complete	□ Unilateral □ Bilateral	____/_____/____	____/_____/____	____/_____/____
□	Bladder	□ Partial □ Complete	□ Partial excision □ Complete		____/_____/____	____/_____/____	____/_____/____
□	Bowel	□ Partial □ Complete	□ Partial excision □ Complete		____/_____/____	____/_____/____	____/_____/____
□	Brain	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____

CANCER TREATMENT RELATED SURGERY							
Check if yes	**8.1.1 Surgical Sites Involved:**	**8.1.2 Partial or complete TUMOUR resection**	**8.1.3 Extent of ORGAN resection**	**8.1.4 Surgical sites involved laterality**	**8.1.5 Date of Cancer Related Surgery**		
					Date (dd/MON/yyyy)	**Date** (dd/MON/yyyy)	**Date** (dd/MON/yyyy)
□	Chest	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____
□	Eye	□ Partial □ Complete	□ Partial excision □ Complete	□ Unilateral □ Bilateral	____/_____/____	____/_____/____	____/_____/____
□	Head and Neck (NOS)	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____
□	Kidney	□ Partial □ Complete	□ Partial excision □ Complete	□ Unilateral □ Bilateral	____/_____/____	____/_____/____	____/_____/____
□	Limb	□ Partial □ Complete	□ Amputation □ Limb Salvage		____/_____/____	____/_____/____	____/_____/____
□	Liver	□ Partial □ Complete	□ Partial excision □ Complete		____/_____/____	____/_____/____	____/_____/____
□	Lung	□ Partial □ Complete	□ Partial excision □ Complete	□ Unilateral □ Bilateral	____/_____/____	____/_____/____	____/_____/____
□	Lymph Node	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____
□	Ovary	□ Partial □ Complete	□ Partial excision □ Complete	□ Unilateral □ Bilateral	____/_____/____	____/_____/____	____/_____/____
□	Pelvis/Inguinal	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____
□	Skin	□ Partial □ Complete			____/_____/____	____/_____/____	____/_____/____

CANCER TREATMENT RELATED SURGERY							
Check if yes	**8.1.1 Surgical Sites Involved:**	**8.1.2 Partial or complete TUMOUR resection**	**8.1.3 Extent of ORGAN resection**	**8.1.4 Surgical sites involved laterality**	**8.1.5 Date of Cancer Related Surgery**		
					Date (dd/MON/yyyy)	**Date** (dd/MON/yyyy)	**Date** (dd/MON/yyyy)
☐	Testes	□ Partial □ Complete	□ Partial excision □ Complete	□ Unilateral □ Bilateral	____/_____/____	____/_____/____	____/_____/____
☐	Thyroid	□ Partial □ Complete	□ Partial excision □ Complete		____/_____/____	____/_____/____	____/_____/____
☐	Uterus	□ Partial □ Complete	□ Partial excision □ Complete		____/_____/____	____/_____/____	____/_____/____
☐	Other	□ Partial □ Complete	□ Partial excision □ Complete		____/_____/____	____/_____/____	____/_____/____

☐ **Check this box if multiple pages used.**

8.2 Enter information for all secondary surgeries.

Secondary surgeries are those that are not used as a form of treatment but may be used to deliver care, diagnose or treat complications that may arise as a result of therapy. The intent of this section is to capture utilization of resources.

SECONDARY SURGERIES				
		8.2.2 Date of Secondary Surgery		
Check if yes	**8.2.1 Secondary surgery type**	**Date** (dd/MON/yyyy)	**Date** (dd/MON/yyyy)	**Date** (dd/MON/yyyy)
☐	Allograft repair	____/_____/____	____/_____/____	____/_____/____
☐	Secondary Amputation	____/_____/____	____/_____/____	____/_____/____
☐	Gastrostomy	____/_____/____	____/_____/____	____/_____/____
☐	Ostomy - colostomy	____/_____/____	____/_____/____	____/_____/____
☐	Ostomy - ileostomy	____/_____/____	____/_____/____	____/_____/____
☐	Ostomy - urostomy	____/_____/____	____/_____/____	____/_____/____
☐	Shunt insertion/ventriculostomy	____/_____/____	____/_____/____	____/_____/____
☐	Shunt revision	____/_____/____	____/_____/____	____/_____/____

☐ **Check this box if multiple pages used.**

9.0 Radiation Details

Diagnosis:_____

9.1 Was radiotherapy ever given?

□ Yes □ No (if no, please skip to section 10.0 HCT)

*If yes, enter each radiation treatment used since diagnosis (**exclude radiation therapy given as part of a preparative regimen for hematopoietic cell transplantation**).* Note: If more than one site was irradiated within one treatment plan, enter all site locations. If more than one radiation treatment plan was used, use multiple sheets to capture these separate treatments.

9.2 Start date: ___/___/_____
dd/MON/yyyy

9.3 End date: ___/___/_____
dd/MON/yyyy

(Include the dates of the boost in the above timeframe)

9.4 Intent of radiation:

□ Curative
□ Palliative
□ Other, specify: _____
□ Not available

9.5 Type of radiation:

□ Photon External Beam
□ Brachytherapy
□ Electron
□ IMRT/Tomotherapy
□ Proton
□ Stereotactic (gamma-knife, cyber knife)
□ Nuclear Therapies (includes radioactive iodine, High-dose MIBG)**
□ Other, specify: _____
□ Not available

9.5.1 Nuclear Therapies

□ Radioactive iodine
□ High-dose MIBG
□ Other, specify_____

9.5.2 Systemic Dose of Radiation
_____
□ Not available

9.5.3 Unit of Measurement:
□ mCi □ MBq □GBq
□ Not available

****Note: If entering systemic therapy, complete sections 9.1-9.5.3. After that-skip to section 10.**

9.6 Radiation site: Select all that apply

Specify general site: e.g. kidney = abdomen (left or right)

- ☐ Abdomen – hemi
- ☐ Abdomen/flank – whole
- ☐ Abdomen/flank – left
- ☐ Abdomen/flank – right
- ☐ Brain: infratentorial
- ☐ Brain: partial
- ☐ Brain: supratentorial
- ☐ Brain: whole
- ☐ Chest wall – left
- ☐ Chest wall – right
- ☐ Craniospinal
- ☐ Face
- ☐ Inverted Y nodes
- ☐ Limb – lower – left
- ☐ Limb – lower – right
- ☐ Limb – upper – left
- ☐ Limb – upper – right
- ☐ Liver
- ☐ Lung-bilateral
- ☐ Lung-left
- ☐ Lung-right
- ☐ Lymph nodes - abdominal
- ☐ Lymph nodes - axilla
- ☐ Lymph nodes - head and neck
- ☐ Lymph nodes - inguinal/femoral
- ☐ Lymph nodes - Mediastinum/hilar
- ☐ Lymph nodes - pelvic
- ☐ Lymph nodes - other
- ☐ Mantle nodes
- ☐ Mediastinum
- ☐ Nasopharynx
- ☐ Neck
- ☐ Orbit – Left
- ☐ Orbit – Right
- ☐ Parotid
- ☐ Pelvis
- ☐ Scalp
- ☐ Skull
- ☐ Spine- cervical
- ☐ Spine- lumbar
- ☐ Spine- sacrum
- ☐ Spine- thoracic
- ☐ Spine- whole
- ☐ Spleen
- ☐ Testis
- ☐ Other, specify: _____
- ☐ Not available

9.7 Total radiation dose: _____cGy (excluding boost)

☐ Not available

9.8 Number of fractions: _____

☐ Not available

9.9 Multiple fractions per day?

- ☐ Yes
- ☐ No
- ☐ Not available

9.10 Was a boost dose given?

□ Yes
□ No
□ Not available

9.11 Boost Technique:

□ Photon External Beam
□ Brachytherapy
□ Electron
□ IMRT/Tomotherapy
□ Proton
□ Stereotactic (gamma-knife, cyber knife)
□ Nuclear Therapies (includes radioactive iodine, High-dose MIBG)

□ Other, specify: _____
□ Not available

9.12 Boost site: Select all that apply

- ☐ Abdomen – hemi
- ☐ Abdomen – whole
- ☐ Abdomen/flank – left
- ☐ Abdomen/flank – right
- ☐ Brain: infratentorial
- ☐ Brain: partial
- ☐ Brain: supratentorial
- ☐ Brain: whole
- ☐ Chest wall – left
- ☐ Chest wall – right
- ☐ Craniospinal
- ☐ Face
- ☐ Inverted Y nodes
- ☐ Limb – lower – left
- ☐ Limb – lower – right
- ☐ Limb – upper – left
- ☐ Limb – upper – right
- ☐ Liver
- ☐ Lung-bilateral
- ☐ Lung-left
- ☐ Lung-right
- ☐ Lymph nodes - abdominal
- ☐ Lymph nodes - axilla
- ☐ Lymph nodes - head and neck
- ☐ Lymph nodes - inguinal/femoral
- ☐ Lymph nodes - Mediastinum/hilar
- ☐ Lymph nodes - pelvic
- ☐ Lymph nodes - other
- ☐ Mantle nodes
- ☐ Mediastinum
- ☐ Nasopharynx
- ☐ Neck
- ☐ Orbit – Left
- ☐ Orbit – Right
- ☐ Parotid
- ☐ Pelvis
- ☐ Scalp
- ☐ Skull
- ☐ Spine- cervical
- ☐ Spine- lumbar
- ☐ Spine- sacrum
- ☐ Spine- thoracic
- ☐ Spine- whole
- ☐ Spleen
- ☐ Testis

☐ Other, specify: _____

☐ Not available

9.13 Total boost dose: _____cGy
(dose from 9.7 + boost dose) ☐ Not available

9.14 Number of boost fractions: _____
(does not include fractions from 9.8) ☐ Not available

9.15 Were additional boosts given?

- ☐ Yes
- ☐ No
- ☐ Not available

☐ **Use multiple pages as required. Check box if multiple pages used.**

10.0 Cellular Therapy Includes Hematopoietic Cell Transplantation or CAR-T Details

Diagnosis:_____

10.1 Was cellular therapy ever performed?

□ Yes □ No (if no, please skip to section 11.0 Hospitalizations)

*If yes, enter each hematopoietic cell transplant or cellular therapy given since diagnosis (**includes conditioning regimen**)*

10.2 Date of transplant or cell infusion: _____/_____/_____

dd/MON/yyyy

Date of actual stem cell or cellular therapy infusion, not pre-hematopoietic transplant radiation or chemo conditioning.

10.2.1 Type of cellular therapy:

□ Hematopoietic stem cell transplant – complete everything but CAR-T fields (10.17 and 10.18)
□ Chimeric antigen receptor therapy – complete 10.3, 10.16 and CAR-T fields (10.17 and 10.18)

10.3 Transplant centre :

□B.C. Children's Hospital
□Alberta Children's Hospital
□Children's Hospital of Winnipeg
□Montreal Children's Hospital
□Centre Hospitalier Universitaire de Sainte Justine
□The Hospital for Sick Children
□Other, specify code: _____
□Not available

10.4 Source of Hematopoietic Cells (include all that are applicable):

□Bone marrow
□Cord blood
□Peripheral blood stem cells

10.5 Donor Type Broad:

□ Allogeneic
□ Autologous
□ Syngeneic
□ Not Available

10.5.1 Donor Type specific: [if allogeneic]

□ Unrelated
□ Parent
□ Sibling
□ Other family donor

10.6 Degree of HLA Match

Number of matched HLA loci: ____
Total number of HLA loci evaluated:____

10.7 Was there T-cell depletion? (allogeneic transplants only)

□ Yes, in vivo conditioning (campath/ATG/ALG)
□ Yes, ex vivo (CD34 selection, T-cell depletion)
□ Yes, in vivo post-transplant cyclophosphamide
□ No

10.8 Date the pre-HCT conditioning regimen (irradiation or drugs) started?

Date: ____/____/_____
(dd/MON/yyyy)

10.9 Type of transplant related irradiation received:

□No irradiation
□Total body irradiation
□ Total lymphatic irradiation (TLI)
□Not available

10.10 Total radiation dose: _____cGy

[not including any additional boosts]

10.11 Number of fractions: _____

10.12 Multiple fractions per day?

□ Yes □ No □ Not available

10.13 Radiation start date: ___/___/_____
dd/MON/yyyy

10.14 Radiation end date: ___/___/_____
dd/MON/yyyy

10.15 What was the intensity of the conditioning regimen?

□ Myeloablative
□ Reduced Intensity
□ Not Available

10.16 Was chemotherapy used with cellular therapy including HSCT (either conditioning or GVHD prevention)?

□ Yes □ No □ Not available

Agents highlighted in Grey require the completion of a separate Chemotherapy Details form.

Agent *Select all that apply*	**Check if administered For GVHD or HSCT**	**Check if administered For CAR-T**	**Chemotherapy details completed**
Alemtuzumab, Campath	□		
Antithymocyte globulin (ATG/ATGAM)	□		
Busulphan, Busulfan, (Myleran)*	□	□	□
Carboplatin, CBDCA, Paraplatin, Carboplatinum	□		
Carmustine (BCNU), Bis-Chloroethyl-Nitrosourea, BiCNU*	□		□
Cisplatin, CDDP, Platinol, Cisplatinum, Cis-diamminedicloro-platinum II, P*	□		□
Cyclophosphamide, Cytoxan, CTX, Procytox*	□	□	□
Cyclosporin	□		
Cytarabine, Ara-C, Cytosar, Cytosine arabinoside (IM, sub q, PO OR IV)	□	□	
Etoposide (VP16), VePesid, ETOP*	□	□	□
Etoposide Phosphate*	□	□	□
Fludarabine, FAMP, Fludara	□	□	
Gemcitabine (Gemzar)	□		
Ifosfamide, Isophosphamide, IFOS, Ifex, Holoxan*	□		□
Melphalan, L-PAM, Alkeran, L-sarcolysin*	□		□
Methotrexate, MTX, amethopterin (IM, sub q, PO OR IV <500mg/m^2 per dose)	□		
MMF (Mycophenolate Mofetil, CellCept)	□		
Prednisone (Methylprednisone, Prednisolone)	□		
Rituximab, Rituxan	□		
Sirolimus	□		
Tacrolimus	□		
Thiotepa, TESPA, Triethylene Thiophosphoramide*	□		□
Treosulfan*	□		□

10.17 CAR-T cell type

- □ CD19
- □ CD22
- □ Other, specify: _____

10.18 CAR-T cell product

- □ Kymriah
- □ Yescarta
- □ Other, specify: _____

PLEASE NOTE: DONOR LYMPOCYTE INFUSIONS ARE CAPTURED IN SECTION 14.0

□ **Use multiple pages as required. Check box if multiple pages used.**

11.0 Hospitalizations (inpatient only)

Enter each in-patient hospitalization & reason for admission. Include all hospitalizations (including the one in which diagnosis was made) but DO NOT include day care admissions. The first admission date can be before the date of definitive diagnosis; however, it cannot be before the date of first health care contact for initial symptoms.

Category	Description
A	Cancer related (diagnosis, staging, treatment) or any complication due to cancer or treatment that precipitates or prolongs hospitalization
C	Hematopoietic cell transplantation related
D	Non-cancer related
E	Not available

11.1 Date of Admission (dd/MON/yyyy)	11.2 Date of Discharge (dd/MON/yyyy)		11.3 Reason for Admission (check all that apply)				
			A		C	D	E
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐
______/______/______ ☐ Not available	______/______/______ ☐ Not available		☐		☐	☐	☐

☐ **Use multiple pages as required. Check box if multiple pages used.**

12.0 Complications

The following complications listed are the only complications that CYP-C is capturing. Please refer to the Data Manual for descriptions and reference to grading system if applicable. **Please note that for data abstraction, Common Terminology Criteria for Adverse Events (CTCAE) version 3 should be used for all complications up to the end of 2010. Complications starting on or after January 1, 2011 should be abstracted with CTCAE version 4. Complications starting on or after April 1, 2018 should be abstracted with CTCAE version 5.**

12.1 Did the patient experience a major complication?

12.1 Check if yes	12.2 Complication Type	12.3 SELECT GRADE	12.4 Date (dd/MON/yyyy)
Auditory			
☐	Hearing impaired (loss)	3 4	____/_____/____
		3 4	____/_____/____
Cardiac			
☐	Heart Failure (Left ventricular dysfunction (LVD))	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
Endocrine			
☐	Diabetes insipidus (deficiency of antidiuretic hormone or low ADH)	☐ Present	____/_____/____
☐	Growth Hormone Deficiency	☐ Present	____/_____/____
☐	Hypothyroidism	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
☐	Primary Ovarian Failure	☐ Present	____/_____/____
☐	Adrenal insufficiency, Hypoadrenalism (Addison)	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
Hemorrhage			
☐	Hemorrhage, CNS	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
Infection			
☐	COVID-19 Infection	1 2 3 4 5	____/_____/____
		1 2 3 4 5	____/_____/____
		1 2 3 4 5	____/_____/____

12.1 Check if yes	12.2 Complication Type	12.3 SELECT GRADE	12.4 Date (dd/MON/yyyy)
Musculoskeletal/Soft Tissue			
☐	Osteonecrosis (avascular necrosis)	3 4	____/_____/____
		3 4	____/_____/____
Neurology			
☐	Stroke	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
☐	Seizures	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
Pulmonary			
☐	Fibrosis	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
Renal			
☐	Chronic Kidney Disease (Glomerular filtration rate (GFR))	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
Vascular			
☐	Thromboembolic event (Thrombosis/embolism)	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____
☐	Vascular access complication (Thrombosis/ embolism, vascular access-related)	3 4 5	____/_____/____
		3 4 5	____/_____/____
		3 4 5	____/_____/____

☐ **Checked and none of the above complications were found.**

12.1 Check if yes	12.2 Complication Type	12.3 SELECT GRADE	12.4 Date (dd/MON/yyyy)
Hematopoietic Cell Transplantation Complications			
☐	ACUTE Graft vs. Host disease, specify organs affected: ☐ Gastrointestinal Tract ☐ Liver ☐ Skin ☐ Other, specify (eg. Lungs): ___________	2 3 4	____/_____/____
☐	ACUTE Graft vs. Host disease, specify organs affected: ☐ Gastrointestinal Tract ☐ Liver ☐ Skin ☐ Other, specify (eg. Lungs): ___________	2 3 4	____/_____/____
☐	ACUTE Graft vs. Host disease, specify organs affected: ☐ Gastrointestinal Tract ☐ Liver ☐ Skin ☐ Other, specify (eg. Lungs): ___________	2 3 4	____/_____/____
☐	CHRONIC Graft vs. Host disease	☐ Limited ☐ Extensive	____/_____/____
		☐ Limited ☐ Extensive	____/_____/____
☐	Hepatic sinusoidal obstruction syndrome (Veno-Occlusive Disease of the liver)	2 3 4	

☐ **Checked and none of the above complications were found.**

13.0 Relapse Details

Use a separate CRF for each relapse. *Note: Includes all types of cancer relapse as defined according to their protocol/treatment criteria. Before a relapse can occur, a patient would have had a complete response to treatment.*

13.1 Date of relapse: _____/_____/_____
(dd/MON/yyyy)

☐ Not available

13.2 Was the relapse at the primary site?

☐Yes ☐No ☐Not available

13.3 Were there metastases at relapse?

☐Yes ☐No (local relapse only) ☐Not available

↓

13.3.1 If yes, specify metastatic sites (check all general sites that apply):

☐Abdomen (NOS)
☐Adrenal gland-bilateral
☐Adrenal gland-left/right
☐Bladder
☐Bone marrow
☐Bone-multiple
☐Bone-single
☐Brain
☐Breast
☐Cerebrospinal fluid (CSF)
☐Eye
☐Head and neck (NOS)
☐Heart
☐Kidney-bilateral
☐Kidney-left/right
☐Large bowel
☐Liver
☐Lung-bilateral
☐Lung-left/right
☐Lymph nodes-distant
☐Lymph nodes-local/ regional
☐Mediastinum
☐Meninges
☐Muscular tissue (NOS)
☐Ovary – left/right
☐Ovary - bilateral
☐Pancreas
☐Pelvis/Inguinal region (NOS)
☐Peritoneal
☐Pituitary gland
☐Pleura
☐Skin
☐Small bowel
☐Spinal cord
☐Spleen
☐Testes – left/right
☐Testes – bilateral
☐Thyroid
☐Uterus
☐Other, specify:_____
☐Not available

13.4 If additional treatment given to this patient, after their relapse, please complete: Chemotherapy List, Chemotherapy Details, Surgery and HCT as required.

14.0 Other Therapies

Diagnosis:_____

14.1 Did the patient have any of the following alternative treatments (please check all that apply)?

☐ Yes ☐ No (if no, please skip to section 15.0 Death Details)

Check if yes	14.2 Other Therapy	14.3a Date of Procedure (dd/MON/yyyy)	14.3b Date of Procedure (dd/MON/yyyy)	14.3c Date of Procedure (dd/MON/yyyy)
☐	Cryotherapy	____/____/____	____/____/____	____/____/____
☐	Laser therapy	____/____/____	____/____/____	____/____/____
☐	Donor lymphocyte infusion	____/____/____	____/____/____	____/____/____
☐	Transarterial chemo-embolization	____/____/____	____/____/____	____/____/____

☐ **Use multiple pages as required. Check box if multiple pages used.**

15.0 Death

15.1 Has the patient died?

□ Yes, date of death:

15.1.1 ____/____/_____
(dd/MON/yyyy)

□ Yes, date not available
□ No
□ Unknown

15.2 Cause of death:

□ Died of progressive disease
□ Died of treatment-related mortality
□ Unknown

16.0 Patient Transfer

To be completed only if patient is *permanently* transferred from one CYP-C centre to another CYP-C centre.

Note: If patient was only temporarily transferred (e.g. for a specific procedure, transplant, etc.) *do not complete this form.* If the patient has been transferred to a non-CYP-C centre (regional hospital, adult cancer centre, etc.), your centre is still responsible for the collection of CYP-C data on this patient and therefore the patient cannot be transferred. Continue to complete data collection.

During your review of CYP-C charts if you realize that the patient was transferred either from your centre or to your centre, contact should be made with the other centre's CRA to ensure that only one CYP-C record is created. The diagnosing institution should be responsible to complete their portion of the 60 month follow-up and then request the official transfer.

The date of official transfer should be the first date that the patient is seen at the receiving centre.

Procedure:

1. Sending institution, complete page 2 and send via fax or mail along with the completed forms to the receiving institution.

2. Receiving institution, complete page 3 and fax back to sending institution to confirm conditional acceptance of the patient transfer.

- The receiving institution must have current IRB approval for the study.

- Data submission, corrections or modifications that are required for data generated prior to the transfer will be the responsibility of the sending institution. However, after the official transfer has been made, only the receiving institution will have write-access to this data. The sending institution must notify the receiving institution of any changes as the receiving institution will be responsible for making changes to the database.

- The transferred record retains its original and unique CYP-C number even after it has been transferred to another participating CYP-C centre.

Database Procedure:

1. Sending institution will request a transfer in the database.
    a. Inputs *receiving institution* and *date of transfer*.

2. Receiving institution will be notified of the transfer request
    a. They will have access to review the chart and ensure that the information has been inputted and is up to date
    b. After a period of time they will have the option to accept or reject the transfer.

CYP-C# _____

TRANSFER FORM

Today's Date _____

Patient's First Name _____ Patient's Last Name _____

Patient's Date of Birth _____ Patient's Gender _____ CYP-C # _____

Sending Institution

- ☐ B.C. Children's Hospital
- ☐ Alberta Children's Hospital
- ☐ Stollery Children's Hospital
- ☐ Saskatoon Cancer Centre
- ☐ Allan Blair Cancer Centre
- ☐ CancerCare Manitoba
- ☐ Children's Hospital, LHSC / Children's Hospital of Western Ontario
- ☐ McMaster Children's Hospital
- ☐ The Hospital for Sick Children
- ☐ Kingston General Hospital
- ☐ Children's Hospital of Eastern Ontario
- ☐ Centre Hospitalier Universitaire de Ste. Justine
- ☐ Montreal Children's Hospital
- ☐ Centre Hospitalier Universitaire de Sherbrooke
- ☐ Centre Hospitalier Universitaire de Québec
- ☐ Izaak Walton Killam Health Centre
- ☐ Janeway Children's Health and Rehabilitation Centre

CRA : _____

Telephone Contact Number: _____

Fax Number: _____

Email Address: _____

Requested Date of Transfer: (date first seen at receiving centre)

_____

Is data submission current on this patient? ☐ Yes ☐ No

Transfers cannot take place unless data is current to the date of transfer.

You are responsible for all data prior to the transfer date, including performance monitoring and audit. Please send a copy of all the completed forms to the receiving centre.

Signature of Sending Institution CRA _____ Date _____

CYP-C# _____

TRANSFER FORM

Receiving Institution

- ☐ B.C. Children's Hospital
- ☐ Alberta Children's Hospital
- ☐ Stollery Children's Hospital
- ☐ Saskatoon Cancer Centre
- ☐ Allan Blair Cancer Centre
- ☐ CancerCare Manitoba
- ☐ Children's Hospital, LHSC / Children's Hospital of Western Ontario
- ☐ McMaster Children's Hospital
- ☐ The Hospital for Sick Children
- ☐ Kingston General Hospital
- ☐ Children's Hospital of Eastern Ontario
- ☐ Centre Hospitalier Universitaire de Ste. Justine
- ☐ Montreal Children's Hospital
- ☐ Centre Hospitalier Universitaire de Sherbrooke
- ☐ Centre Hospitalier Universitaire de Québec
- ☐ Izaak Walton Killam Health Centre
- ☐ Janeway Children's Health and Rehabilitation Centre

CRA: _____

Telephone Contact Number: _____

Fax Number: _____

Email Address: _____

You will be responsible for all data from the date of transfer, including performance monitoring and audit).

Signature of Receiving Institution CRA _____ Date _____