
PATIENT SCREENER/NONRESPONSE FORM

Study Site: _____ Completed by: _____

PART ONE: PATIENT SCREENER

1. Is this patient a case or a control (as defined by the CCTS)?

(Circle One)

Case 1 → CONTINUE

Control..... 2 → GO TO QUESTION 3

2. If Case:

What trial is the patient enrolled in?

Trial ID #: _____

3. If Control:

For which trial(s) is the patient being matched as a control?

Trial ID #: _____

4. Did the patient agree to let RAND contact them about the study?

(Circle One)

Yes 1 → CONTINUE

No 2 → GO TO QUESTION 7,
SECTION THREE

10. What main racial or ethnic group does the patient belong to?

(Circle One)

White, not Hispanic 1

African American 2

Hispanic 3

Other/Unknown 4

11. What type of cancer does the patient have and what was the stage at diagnosis?

(Circle All That Apply and Write in Stage at Diagnosis)

Lung 1 _____

Prostate 2 _____

Colon..... 3 _____

Rectal 4 _____

Colorectal 5 _____

Leukemia 6 _____

Lymphoma 7 _____

Breast 8 _____

Ovarian 9 _____

Cervix 10 _____

Endometrium..... 11 _____

Uterus 12 _____

Melanoma 13 _____

Glioma 14 _____

Other (specify) 15 _____

PATIENT BACKGROUND INFORMATION—CONTINUED

12. For the most recent hospitalization:

a. What was the date of admission? _____/_____/_____
Month Day Year

b. What was the date of discharge? _____/_____/_____
Month Day Year

c. What was the patient's disposition status?

(Circle One)

- Discharged Home (with or without follow-up) 1
- Discharged Home, with Home Health Care 2
- Discharged AMA (Against Medical Advice) 3
- Deceased 4
- Transfer to Hospice Care (Inpatient or Outpatient) 5
- Transfer to Another Acute Care Facility 6
- Transferred to Long Term Care Facility-Rehabilitation 7
- Transferred to Long Term Care Facility-Skilled Nursing 8
- Transferred to Long Term Care Facility-Nursing 9
- DON'T KNOW DK

13. **This patient approved the release of the above information to RAND, under the agreement that it will only be used for The Cost of Cancer Treatment Study (CCTS) and will be kept strictly confidential.**

AFFIRMED BY:

_____ Name (please print)

_____ Date:

(signature)

OF:

_____ (Institution)

<p>PLEASE MAIL OR FAX THIS FORM TO: KATHRYN DAVIS RAND 1700 Main St. Santa Monica, CA 90407 Tel: (310) 393-0411, ext. 7267 Fax: (310) 451-6921</p>
