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
PART TWO: PATIENT CONTACT INFORMATION

5. Sampled Patient Medical Record Number or Patient ID: ________________________________

6. a. Patient Name: ________________________________________________________________

            First   Middle   Last

            ____________________________

b. Street Address: ________________________________________________________________


f. Phone Number:  Home: (_____)_____-_______

g. Work: (_____)_____-_______

PART THREE: PATIENT BACKGROUND INFORMATION

7. If the patient does not want RAND to contact them, will they allow the release of anonymous background information to RAND?

(Circle One)

Yes ............... 1  —> CONTINUE

No ................. 2  —> GO TO QUESTION 13

8. What is the patient’s gender?

(Circle One)

Male ............. 1

Female ........... 2

9. What is the patient’s date of birth? _____/_____/_____

            MO   DAY   YR
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)

PLEASE MAIL OR FAX THIS FORM TO:
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Santa Monica, CA 90407
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