Treatment Information Form
INTERTECC Trial
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Instructions: Submit this form at the completion of radiotherapy. This form is to be completed by a researcher or clinical staff member.

1. Date Radiation Therapy Started: ________________ Day / Month / Year
2. Date External Beam RT Ended: ________________ Day / Month / Year
3. External Beam Radiation Total Fractions (#):_______________
4. External Beam Radiation Total Dose (Gy):______________
5. Was daily in-room IGRT used?
   ☐ No
   ☐ Yes, planar images (e.g., kV setup films) only
   ☐ Yes, volumetric images (e.g., cone beam CT) only
   ☐ Yes, planar and volumetric images
6. Was a parametrial boost given?
   ☐ No
   ☐ Yes
7. Brachytherapy Dates (if applicable):
   Implant #1: ________________________________ Day / Month / Year
   Implant #2: ________________________________ Day / Month / Year
   Implant #3: ________________________________ Day / Month / Year
   Implant #4: ________________________________ Day / Month / Year
   Implant #5: ________________________________ Day / Month / Year
8. What type of brachytherapy was used (if applicable)?
   ☐ Low dose rate (LDR)
   ☐ High dose rate (HDR)
9. Was volume-directed brachytherapy used (if applicable)?
   ☐ No
   ☐ Yes
10. Brachytherapy Total Mean Dose to Point A (Gy):____________
11. Were there any unscheduled interruptions in radiotherapy?
   ☐ No
   ☐ Yes, reason(s): ________________________________
12. Reason Treatment Ended
   ☐ Treatment completed per protocol criteria
   ☐ Treatment completed per modified protocol (e.g. patient stopped chemotherapy but continued radiation only)
   ☐ Treatment ended early due to Adverse event / side effects / complications
   ☐ Disease progression / relapse during treatment
   ☐ Patient or Physician withdrawal / refusal
   ☐ Death
   ☐ Other: ________________________________
13. Cycles of Chemotherapy Planned (#):______________
14. Dates and Doses of Chemotherapy:
   Cycle #1: ____________________________ Day / Month / Year Cis. Dose (mg) Gem. Dose (mg)
   Cycle #2: ____________________________ Day / Month / Year Cis. Dose (mg) Gem. Dose (mg)
   Cycle #3: ____________________________ Day / Month / Year Cis. Dose (mg) Gem. Dose (mg)
   Cycle #4: ____________________________ Day / Month / Year Cis. Dose (mg) Gem. Dose (mg)
   Cycle #5: ____________________________ Day / Month / Year Cis. Dose (mg) Gem. Dose (mg)
15. Cycles of Chemotherapy Held (#):______________
16. Reason Chemo Held (if applicable; check all that apply):
   ☐ Hematologic toxicity / low blood counts
   ☐ Nephrotoxicity
   ☐ Ototoxicity
   ☐ Nausea / emesis
   ☐ Patient withdrew consent for chemotherapy
   ☐ Other: ________________________________
17. Did the patient receive one or more packed RBC transfusions?
   - No
   - Yes, within 4 weeks prior to RT (total # of units):__________
   - Yes, during RT (total # of units):_______________________

18. Did the patient receive one or more platelet transfusions?
   - No
   - Yes, within 4 weeks prior to RT (total # of units):__________
   - Yes, during RT (total # of units):_______________________

19. Did the patient receive granulocyte/monocyte colony stimulating or growth factors (e.g., filgrastim)?
   - No
   - Yes, within 4 weeks prior to RT (total # of units):__________
   - Yes, during RT (total # of units):_______________________

20. Did the patient receive hematopoietic growth factors (e.g., erythropoietin)?
   - No
   - Yes, within 4 weeks prior to RT (total # of units):__________
   - Yes, during RT (total # of units):_______________________

21. Was the patient hospitalized during RT?
   - No
   - Yes, reason(s):__________________________________________

Comments:_______________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

Investigator Signature _________________________________________  Date _______________________________