Manual for the Completion

of the

NCI / CCR / C^{3}D

COTC001

Case Report Forms

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Manual for the Completion of the NCI / CCR / C^{3}D COTC001 Case Report Forms

Disclaimer:

This manual was developed by Harris Technical Services Corporation (HTSC) for the National Cancer Institute's Center for Cancer Research (CCR). The material contained in it is solely for assisting data entry into CCR's Cancer Central Clinical Database (C^{3}D) electronic case report forms.

Table of Contents

Introduction

At the end of 2003, the National Cancer Institute's Center for Cancer Research (CCR) developed and started using the Cancer Central Clinical Database (C^3D) - a client-server computer system - to capture data for oncology clinical trials research trials conducted at the CCR.

This manual contains the instructions for the completion of the NCI's standard Case Report Forms (CRF) used in C^3D.

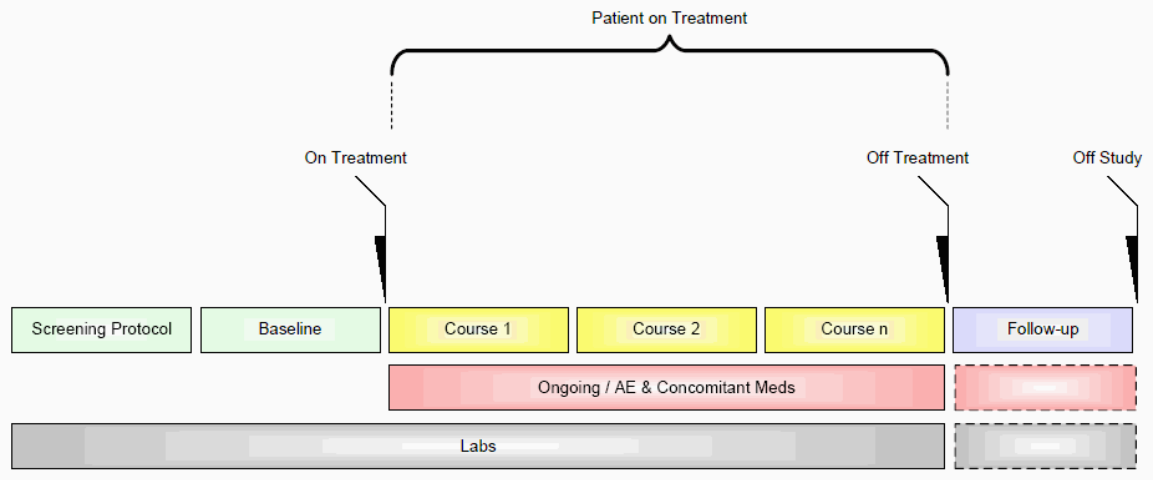
The eCRF instruction manual is preceeded by a General Instructions section which describes topics applicable to all eCRFs.This is followed by instuctions for each form which include how to complete each field, what the validation rules are for the CRF, and what fields will be derived by the database. The Appendices include conversion tables and useful Internet and Intranet references.

General Instructions

Data Entry Chronology

Case Report Forms should be created and completed in chronological order as follows:

1. Screening CRFs and any labs needed to support eligibility.
2. Each course in sequential order including:
   - Course Initiation,
   - Study Medication Administration,
   - Pharmacokinetics, if applicable
   - Physical Exam,
   - Course Assessment, and
   - Any additional cycle specific CRFs.
3. At completion of patient's treatment, Off Treatment CRF.
4. If the protocol specifies a follow-up period after the treatment, complete the Follow-up and any other applicable follow-up CRF - manually complete the labs CRFs done after the date off treatment since those will no longer be automatically loaded.
5. At end of study, when the follow-up period is completed, enter the Off Study CRF.
6. If the patient dies during treatment or follow-up period, complete the Survival, Off Treatment and Off Study CRFs.



Data Reporting

Complete the CRFs according to the protocol and in a timely manner. Studies reporting to CTMS submit data every two weeks. Studies reporting to CDUS submit data every three months. Other studies might have different reporting requirements.

General Instructions

Electronic Case Report Forms

An electronic CRF in Oracle Clinical is called a DCI - data collection instrument.
In C3D, these CRFs always have three fields at the top:

1. Visit Date (see Entering Dates below)
2. Blank check box (see Blank Case Report Forms below)
3. Comments (see Blank Case Report Forms below)

Below these fields, there are at least two tabs (also known as DCM - data collection module). For example: In the Prior Radiation CRF, the first tab is used to collect information about the patient's prior radiation treatments while the second tab is used to collect comments about the prior radiation treatments.

Blank Case Report Forms

Mark a complete CRF blank whenever there is no information to enter in it. For example: Place a check on the Prior Radiation CRF Blank check box to indicate that a patient has never received radiation treatment prior to enrollment. Optionally, enter some explanation, in the Comments field next to the Blank check box, to indicate why the entire CRF is blank.

Entering Comments

Each CRF has a section for entering multiple comments about the data entered in the CRF. This area is always the last tab in the CRF. Enter the date and the applicable comments.

Entering Dates

Ongoing CRFs:

Visit date is an optional field (can be left blank).

Course-specific CRFs:

Refer to each eCRF's instructions for specific directions on what must be entered as visit date. A visit date **cannot** be a partial date.

Note: The current version of Oracle Clinical does not permit the removal or change of the label of the visit date.

Complete dates (day, month, year):

Entered in the U.S. format: month, day and year. That is the default date format in the Oracle Clinical RDC. Dashes (-) and slashes (/) do not need to be entered, simply the numbers. To enter the year in a century format use YYYY, since years

higher than the current one default to the previous century. The recommended entry format for complete dates is: MMDDYYYY.

Partial dates (month and year or simply year):

Only acceptable in a few places such as baseline symptoms and patient's history.

- For year only, use 00-00-YYYY.
- For month and year, use 00-MON-YYYY.

Partial dates are not acceptable for dates that fall within the date of registration and date off study since the complete dates for events occurring during the study are known.

The use of 'Ongoing' is limited to the CRFs where patients may still be undergoing a particular cancer therapy, but are still eligible for the study, such as hormonal or radiation therapy.

Future dates:

Not allowed.

Entering Time

All times are to be recorded on a 24 hour clock. Enter 1:00 PM as 13:00 and midnight as 00:00.

Using Pick Lists

A pick list is a selection of acceptable values for a particular field. Once you place the cursor in the field where you will enter data, an ellipsis (···) is displayed to the right of the field which indicates there is a pick list available for you to use. Click on the ellipsis to display the pick list. Whenever possible, select from a pick list to assure accurate and consistent data entry. If a pick list does not contain the entry you need, type in the information. If the entry should be on the pick list or you are typing in a value that is not on the pick list repeatedly, request it to be added to the pick list.

Mandatory Fields

Some fields in a CRF are defined as mandatory. That means information must be entered in them when the form is created. Each CRF instruction sheet will identify mandatory items as a superscript to the right of the field name. (i.e.: $^{(m)}$)

C^3D Support

For assistance with C^3D application issues, please contact the NCICB Application Support Group by phone at 301-451-4384 or by e-mail NCICB@pop.nci.nih.gov .

Case Report Forms

Adverse Events

Purpose

This eCRF is an ongoing form to capture all adverse events experienced by the patient regardless of the course.

An adverse event is any unfavorable or unintended sign, including abnormal laboratory findings, symptom or disease having been absent at baseline, or if present at baseline, appears to worsen, that has a temporal association with a medical treatment or procedure regardless of the relationship of the event to the medical treatment or procedure.

All adverse events will be coded using Veterinary Cooperative Oncology Group – Common Terminology Criteria for Adverse Events (VCOG-CTCAE) Following Chemotherapy or Biological Antineoplastic Therapy in Dogs and Cats v1.0.

Record all adverse events experienced by the patient, including laboratory abnormalities, regardless of relationship to the study medication.

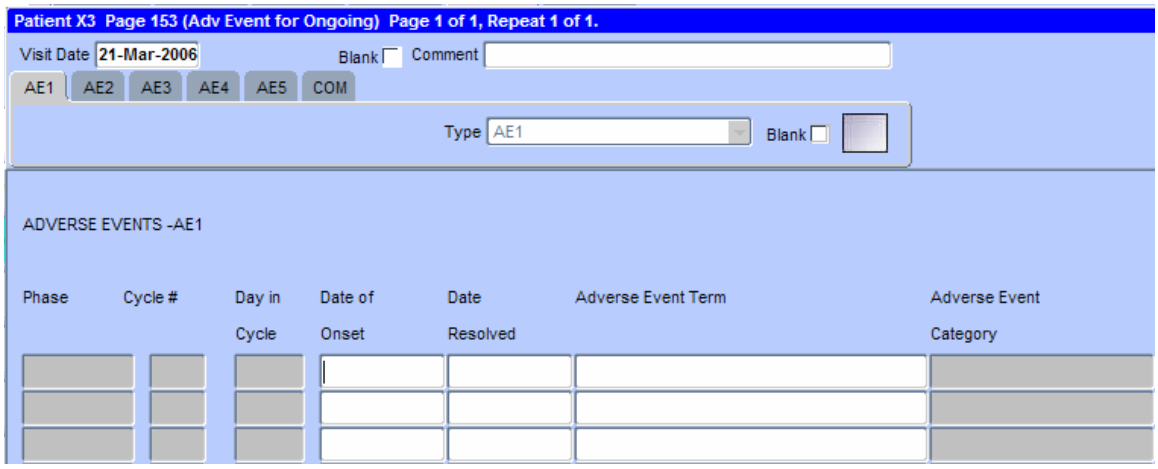
An adverse event entry is composed of both the adverse event term plus the grade. Complete a separate row for each adverse event entry to be reported using the appropriate adverse event term and the appropriate codes for "grade", "attribution", "serious", "action", "therapy", and "outcome" in the respective column for each event.

If an adverse event has not been resolved, leave the Resolved Date blank. The Resolved Date can be filled at a later time when the adverse event is considered resolved. Resolution means a change in grade to a higher or lower grade, to the normal grade (grade zero) or the return to the baseline symptom grade.

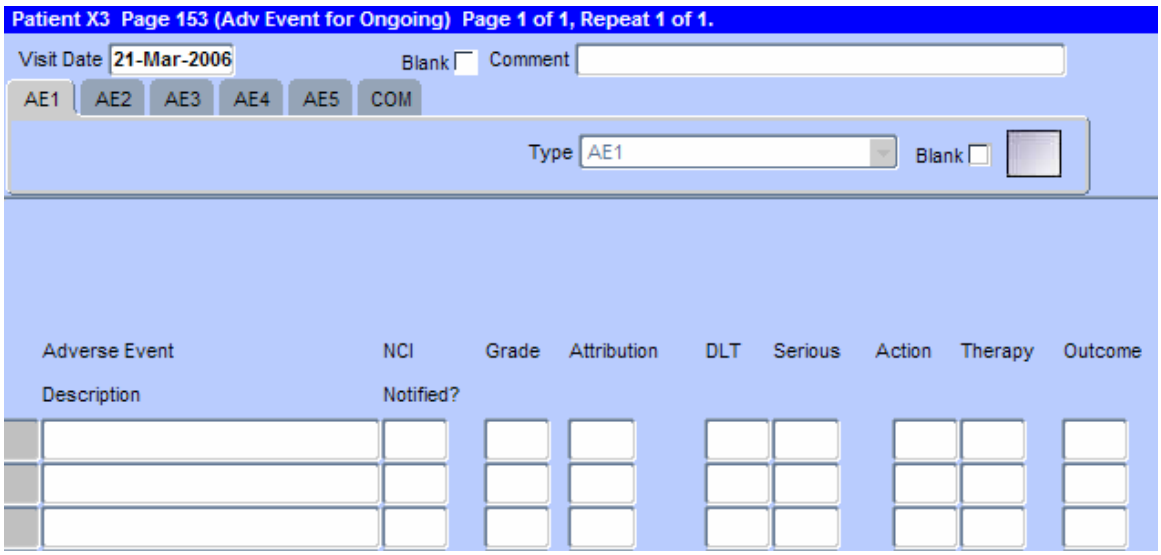
How to record baseline symptoms that change, either improve or worsen:

- If a pre-existing condition resolves, it does not need to be reported as an adverse event since it would have been already recorded on the Baseline Symptoms case report form. Enter the resolution date on the corresponding symptom entry on the Baseline Symptoms case report form.
- If a pre-existing condition worsens (i.e.: the grade of the baseline symptom increases), that constitutes an adverse event entry which must be reported in full detail.
- If a pre-existing condition improves without a resolution, do not enter as an Adverse Event. When it resolves, enter the resolution date on the corresponding symptom entry on the Baseline Symptoms case report form.

Adverse Event eCRF



The following screen shot is the portion to the right of the Adverse Event Description.



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Prior Cycle Adverse Event field.	DD-MMM-YYYY
Phase (d)	Derived as ‘Study 1’ or ‘Study 2’	10 Characters
Cycle # (d)	Indicates the cycle number that this adverse event started in as derived from the cycle initiation start date.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle that this adverse event started as derived from the cycle initiation start date.	5 digits
Date of Onset (m)	Enter the date of first observation of the adverse event and grade.	DD-MMM-YYYY
Date Resolved	Enter the date of resolution of the adverse event and grade. **Leave this field as well as the Outcome field blank if the adverse event is ongoing.** Resolution means a change in grade to a higher or lower grade, to the normal grade (grade zero) or the return to the baseline symptom grade.	DD-MMM-YYYY
Adverse Event Term Term (m)	Using the VCOG-CTCAE v1.0, select the appropriate general category with the appropriate adverse event term. In the absence of a specific adverse event term, choose the "Other" term from the appropriate general category and be sure a meaningful adverse event description is entered in the "adverse event description" field.	Use pick list.
Adverse Event Category (d)	Broad classification of adverse events based on anatomy and/or pathophysiology. Within each category there is the adverse event term/CTC Term Description. *Note: This field is derived from the selected Term.*	40 Characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Adverse Event Description	Enter a **succinct clinical description** of the adverse event. DO NOT enter raw data (i.e.: lab result). Use the term increase or decrease. DO NOT enter the attribution in this field. Use the Attribution field for this purpose. For example: • Enter 'Low back pain' when selecting the term 'Pain: Back'. • Enter 'Intermittent headache' when selecting the term 'Pain Head/Headache' • Enter 'Left arm pain' when selecting the term 'Pain-Other'	100 characters
NCI Notified? (m) ...	Indicate if NCI was notified of the Adverse Event: Y- Yes N- No U- Unknown	Use pick list.
Grade (m) ...	Grade adverse events using the VCOG-CTCAE v1.0. If the protocol does not use VCOG-CTCAE, grade according to the following general criteria: 0. Normal – no adverse event or within normal limits 1. Mild – barely noticeable, does not influence functioning 2. Moderate – makes subject uncomfortable, influences functioning 3. Severe – severe discomfort, treatment given 4. Life threatening – immediate risk of death 5. Fatal – causes death of the patient – **Outcome must be 4-Died.**	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Attribution (m) ▪▪▪	Every entry must be evaluated for relationship to the study therapy. Select one of the following codes to record this evaluation: 7. Unrelated – clearly not related 8. Unlikely – doubtfully related 9. Possible – may be related 10. Probable – likely related 11. Definite – clearly related	Use pick list.
DLT (m) ▪▪▪	Indicate if the adverse event is dose limiting, as defined in the protocol, by entering: Y- Yes N- No *Note: Refer to the protocol for the definition of a dose limiting toxicity which should include the grade of the events and the duration of the event.*	Use pick list.
Serious (m) ▪▪▪	Indicate if the adverse event was a "serious" event by selecting from the following codes, as per the Code of Federal Regulations 21 Part 312. If multiple categories are applicable, select the worst. 1. Not serious. 2. Life-threatening. 3. Death as a result of the adverse event. 4. Disability: significant, persistent or permanent. 5. Hospitalized or prolonged hospitalization (not including emergency room visits). 6. Caused congenital anomaly in offspring of patient. 7. Jeopardizes patient / requires intervention to prevent permanent impairment or damage to patient.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Action (m) ...	Indicate any changes made to the study regimen in response to the adverse event using the following codes. "Action" refers to the decision to reduce or continue the **investigational medication**. 1. None 2. Dose Reduced 3. Regimen Interrupted 4. Therapy Discontinued 5. Interrupted & Reduced If the "Action" for any adverse event is recorded as 2, 3, 4, or 5, the changes in medication administration must be reflected on the Study Medication Administration form. *Note: Interrupted also means therapy was delayed.*	Use pick list.
Therapy (m) ...	Indicate if additional therapy is required to treat the adverse event. 1. None 2. Symptomatic (i.e.: required medications to treat event) 3. Supportive (i.e.: required medications and/or IV fluids, blood products) 4. Vigorous Supportive (i.e.: required surgery, intubation) A corresponding entry of the therapy given to treat the adverse event must be recorded on the Concomitant Measures/Medication form.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Outcome ▪▪▪	Select the final status of the patient when the adverse event is considered "resolved". 1- Recovered – the event (CTCAE term + grade) has resolved to normal or changed to a lower or higher grade. The recovery may be due to the suspension of study treatment or due to concomitant treatments that have ended. 4- Died - Record outcome of death only for adverse events that resulted in the patient's death. *Note: For ongoing adverse events, leave this and the Resolution Date fields empty.* *Note: For deaths on study, only the events which caused the death should have the outcome coded as a "4." The events that were still continuing at the time of the death would still be ongoing. Do not enter a resolved date, and outcome.*	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

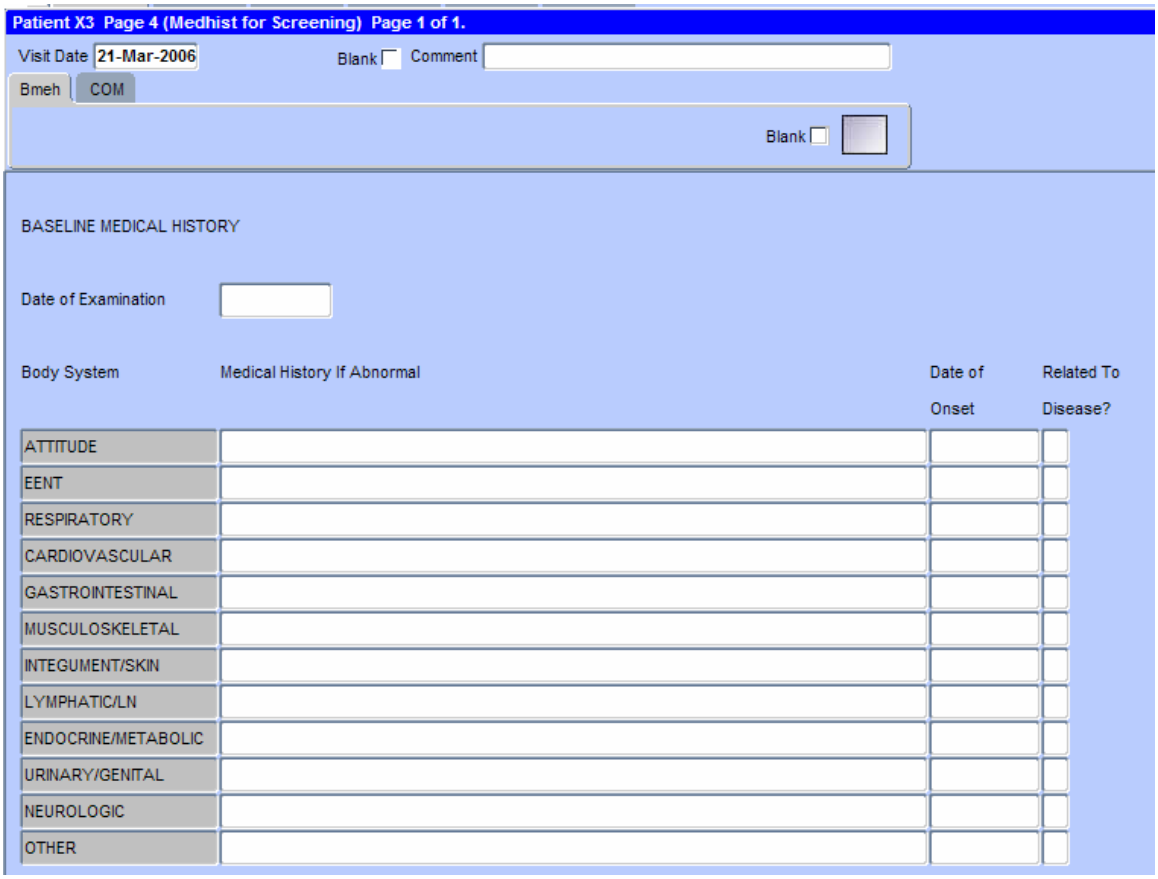
(ADVERSE-EVENTS)

Baseline Medical History

Purpose

Record a brief description of major medical and surgical events during the patient's lifetime, excluding the events related to their cancer therapy.

Baseline Medical History eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Date of Examination (m)	Enter the date that the patient was examined and the medical history was documented. Since only one Baseline Medical History form is used, if the information has been assembled over a period of time, enter the date of the latest examination.	DD-MMM-YYYY
Medical History if Abnormal	Enter a brief description of major medical and surgical events during the patient's lifetime (i.e.: hypertension under cardiovascular, Exploratory surgery for foreign body under abdomen). Enter the history for the appropriate body system to which the information refers. For "Other" indicate the body or organ system in the history.	200 characters
Date of Onset	Enter the date that the symptom was first observed/experienced.	DD-MMM-YYYY
Related to Disease? ▪▪▪	Indicate whether or not the symptom is related to the study disease by selecting one of the following options: Y- Yes N- No U- Unknown	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(BASELINE-MEDICAL-HISTORY)

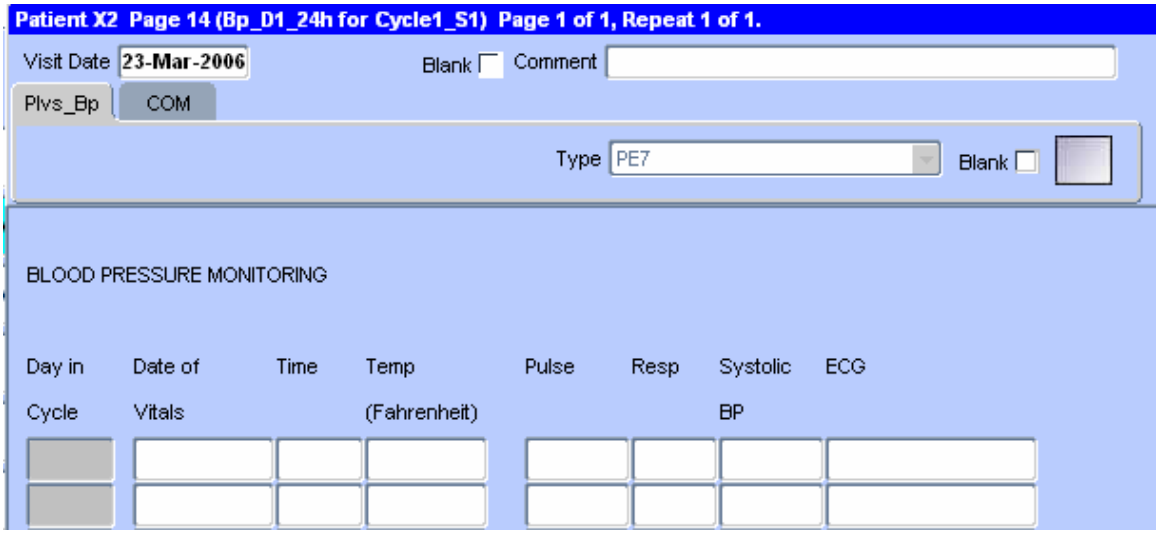
24 Hour Monitoring

Purpose

To capture vital measurements during phage administration and the 24-hour hospitalization that follows.

The actual numerical values should be entered here but if an **Adverse Event** occurs in relation to these measurements, a separate AE eCRF should be filled out.

Monitoring eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Days in the cycle (d)	Indicates the day since the beginning of cycle that this concomitant measure / medication started as derived from the cycle initiation start date.	5 digits
Time	Enter the time the lab sample was collected. Enter midnight as 24:00 since 00:00 is used when time is not known.	HH(24):MM
Temperature (Fahrenheit)	Enter the patient's temperature only in Fahrenheit, to one decimal place.	4 digits and 3 decimals
Pulse	Enter the patient's pulse rate.	4 digits and 3 decimals
Respiration Rate	Enter the patient's respiration rate.	4 digits and 3 decimals
Systolic Blood Pressure	Enter the patient's systolic blood pressure (Doppler measurements are acceptable).	4 digits and 3 decimals
ECG	Enter the patient's ECG reading (Lead II strip).	8 Characters
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(BLOOD PRESSURE MONITORING)

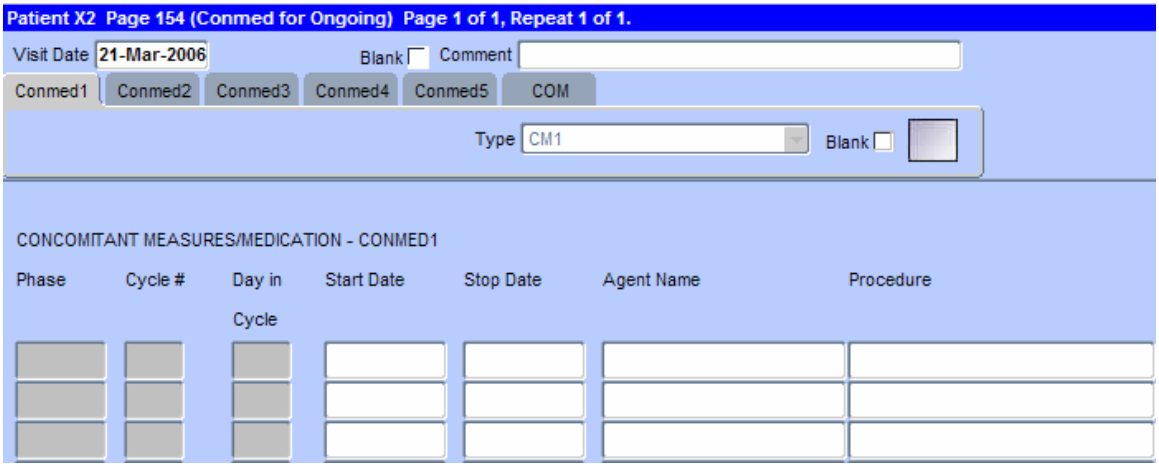
Concomitant Measures / Medications

Purpose

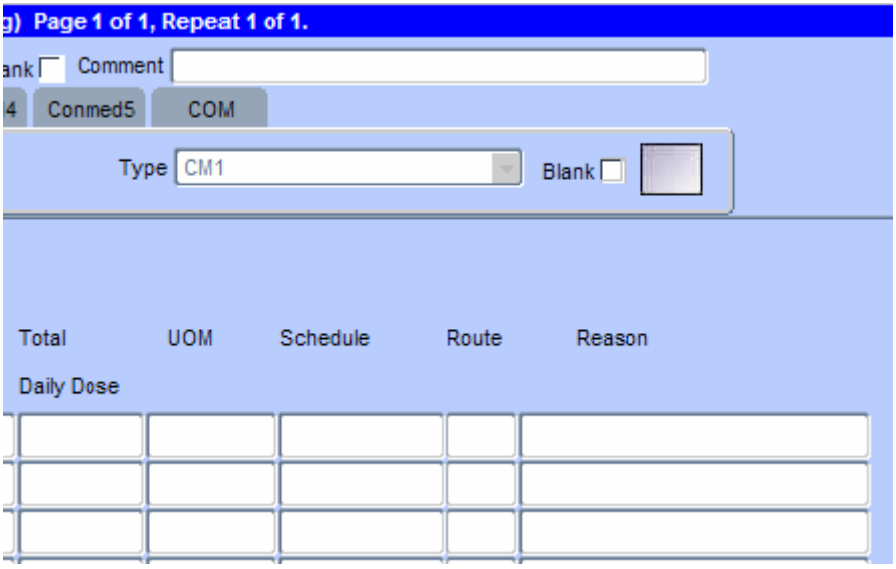
Record all concomitant medications, including therapies given to treat adverse events.

If a patient is taking a medication PRN, do not use a separate line for each time the medication is taken, instead report the first and last dates taken.

Concomitant Measures / Medications eCRF



The following screen shot is the portion to the right of the Procedure field.



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Start Date field.	DD-MMM-YYYY
Phase (d)	Derived as ‘Study 1’ or ‘Study 2’.	10 Characters
Cycle # (d)	Indicates the cycle number that this concomitant measure / medication started in as derived from the cycle initiation start date.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle that this concomitant measure / medication started as derived from the cycle initiation start date.	5 digits
Start Date (m)	Enter the start date of the measure or medication. *Note: Partial date is only acceptable for baseline measure or medication.*	DD-MMM-YYYY or MMM-YYYY
Stop Date	Enter the stop date of the measure / medication. *Note: Partial date is only acceptable for baseline measure or medication.*	DD-MMM-YYYY or MMM-YYYY
Agent Name ...	In the case of agents, state the generic name of the medication administered, or, in the case of combinations such as trimethoprim / sulfamethoxazole, state the brand name (i.e., Bactrim). *Note: Pre and post medications specified in the protocol and administered as part of the patient's treatment, must be entered in the Study Medication Administration case report form.* *Note: All anesthetic medications used for biopsy/surgery should be recorded here.* *Note: Do not select an agent name if a procedure has been entered.*	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Procedure ...	If a procedure/measure, state e.g., oxygen administration, pleural tapping, etc. *Note: Do not select a procedure if an agent name has been entered.*	Use pick list.
Total Daily Dose	Enter the total daily dose of the agent as appropriate. In the case of combinations such as Bactrim, enter the total number of combination tablets taken daily. Enter the maximum possible dose in a 24-hour period when the schedule is PRN. For example: enter 12 when taking 2 tabs of Tramadol PRN every six hours. *Note: If a procedure/measure, leave blank.*	8 characters
UOM ...	Select the total daily dose units of measurement. *Note: If a procedure/measure, leave blank.*	Use pick list.
Schedule	Select the frequency of medication administration or measure under schedule.	24 Characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Route (m) ▪▪▪	Select the route given: IM- intramuscular ID- intradermal IV- intravenous bolus (less than 30 minutes) IVI- intravenous infusion (greater than 30 minutes, but less than 24 hours) CIV- continuous intravenous infusion (greater than 24 hours) IA- intra-arterial IT- intrathecal IP- intraperitoneal IH- intrahepatic IHI- intrahepatic infusion SC- subcutaneous T- topical PO- oral RT- radiation or other route as specified in the protocol.	Use pick list.
Reason (m) ▪▪▪	Select the reason the medication is being administered or why measure done. For example, if Baytril is being given as a prophylactic, select "myelosuppresion prophylaxis". *Note: Do not enter the pharmacological classification of the medication (e.g. antibiotic, analgesic, etc.)*	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

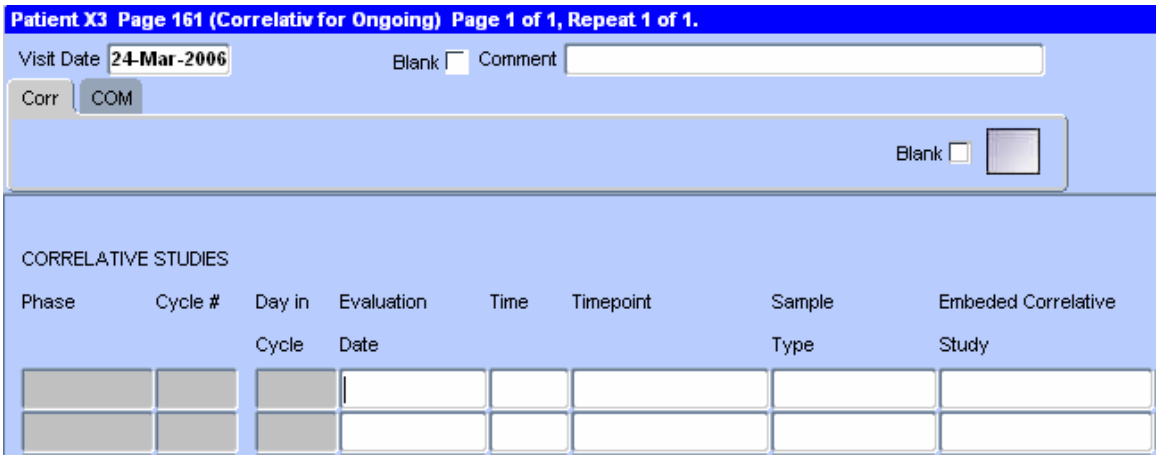
(CONCOMITANT-MEASURES-MEDICATIONS)

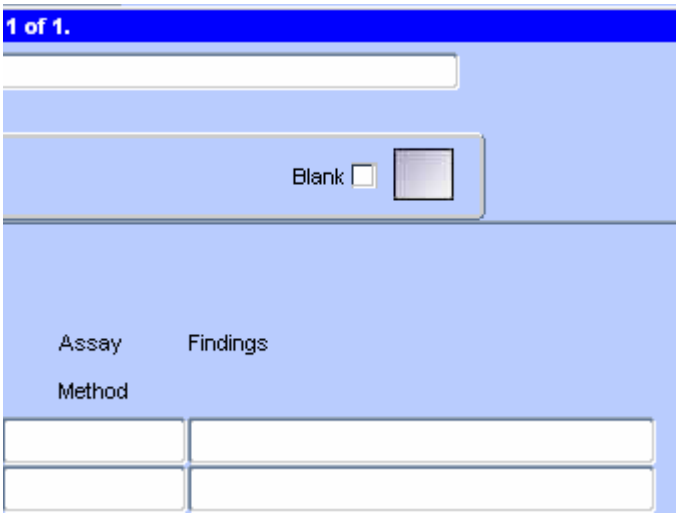
Correlative Studies

Purpose

To record biological information for correlation to clinical study findings. These will include the RT-PCR and IHC results on a per patient and per cohort basis. This eCRF will be filled in ad-hoc after the completion of the study.

Correlative Studies eCRF





Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Phase (d)	Derived as 'Study 1' or 'Study 2'	10 Characters
Cycle # (d)	Indicates the cycle number the procedure is related to based on their date and time.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle the procedure is performed (based on their date and time).	5 digits
Evaluation Date	See above	DD-MMM-YYYY
Time	See above	HH(24):MM
Timepoint ...	Select study time point for the collected sample: Day 0 Day 1 Day 4 Day 7 Day 14 Day 21 Day 28 Pre-Treatment (other) Post-Treatment (other) Necrosis (sample unreadable)	Use pick list
Sample Type	Select sample type: Serum Tumor Tissue Plasma Whole Blood Normal Tissue	Use pick list
Embedded Correlative	Briefly describe goal of assay: RT-PCR- expression levels of TNF-α IHC- phage localization (phage antibody) IHC- vessel density (CD31) IHC- apoptosis (TUNEL) Other	64 characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Assay Method	Indicate Assay method used to obtain results for embedded correlative. Select from the following: RT_PCR IHC Other	Use pick list
Findings?	Briefly describe findings	64 characters
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

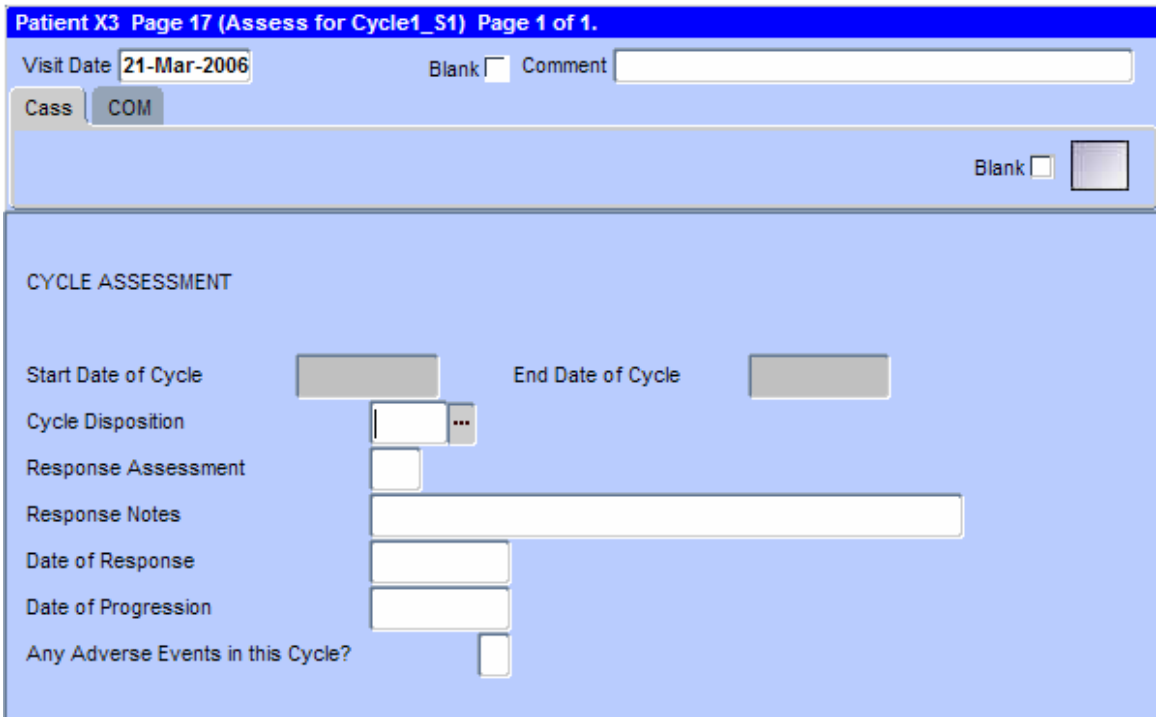
(CORRELATIVE STUDIES)

Cycle Assessment

Purpose

Record the cycle assessment information when the cycle is completed, and the patient is evaluated, or taken off treatment.

Cycle Assessment eCRF



Field Descriptions / Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the cycle ended.	DD-MMM-YYYY
Start Date of Cycle (d)	Shows the Start Date of Cycle entered in the Cycle Initiation case report form.	DD-MMM-YYYY
End Date of Cycle (d)	Shows the derived end date of the cycle which is the day before the start date of the following cycle or the off treatment date.	DD-MMM-YYYY
Cycle Disposition (m) ...	A "completed" cycle is one that has been conducted in accordance with the protocol with respect to length including the observation period (two day variance allowed). A cycle is regarded as "discontinued" if it was shorter than specified in the protocol. Select one of the following values: Comp- Completed Dis- Discontinued	Use pick list.
Response Assessment (m) ...	Select the patient's best disease state as assessed during the cycle. This determination must be adequately documented in the patient's medical record. CR- Complete Response MR- Minor Response PD- Progressive Disease SD- Stable Disease SS- Significant Stabilization NA- Not Assessed - State the reason in the "Response Note" field. NP- Protocol does not require a response assessment during the specific cycle. TE- Too Early to confirm a response.	Use pick list.
Response Notes	Enter the reason why the Response Assessment is Too early to confirm response (TE) or Not Assessed (NA). Some examples could include: protocol not followed, poor quality of scan/measurements, patient already treated.	32 characters

Field Descriptions / Instructions		
Field Name	**Description / Instructions**	**Format**
Date of Response	Enter the date of the earliest evaluation which, upon confirmation, justifies an assessment of CR, PR, MR, SD or SS. This date will be the same date as the measurement/scan, or other method of disease assessment. For NE, record the date the patient's disease was assessed and deemed to be Not Evaluable. *Note: The original date of onset of response should be used for responses that persist through several cycles.*	DD-MMM-YYYY
Date of Progression	Enter the date of the evaluation used to determine the patient's disease status of progressive disease. Enter a date of progression if the disease progression occurred after an assessed better response (i.e. PR, CR, SD).	DD-MMM-YYYY
Any Adverse Events in this Cycle? (m) ...	Select "Yes" if any adverse event has occurred during this cycle. Select "No" if no adverse events occurred during this cycle. *Note: The event(s) must be recorded on the Adverse Events case report form.*	Use pick list.
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(CYCLE-ASSESSMENT)

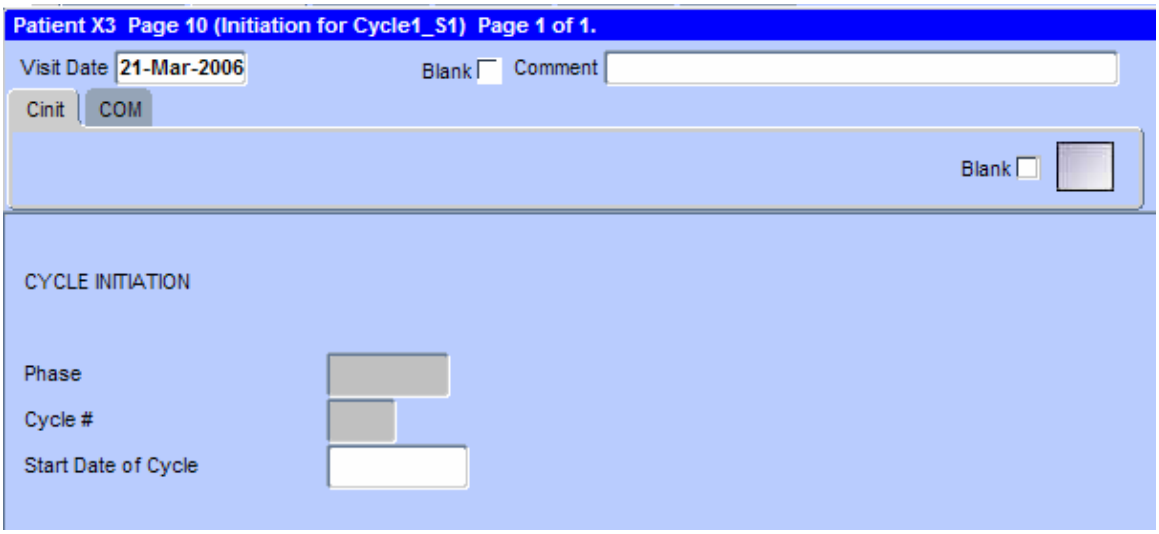
Cycle Initiation

Purpose

Record cycle initiation Start Date.

Cycle Initiation eCRF

Cycle Initiation tab



Field Descriptions / Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the cycle started.	DD-MMM-YYYY
Phase (d)	Derived as 'Study 1' or 'Study 2'	10 Characters
Cycle # (d)	Sequential number of this cycle of treatment: first cycle = 1, second cycle = 2, etc.	5 digits
Start Date of Cycle (m)	Enter the date on which the cycle was started. This is the date on which a protocol stipulated medication (or treatment) was first administered. *Note: This would be Day 0's date.*	DD-MMM-YYYY
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

Eligibility Checklist

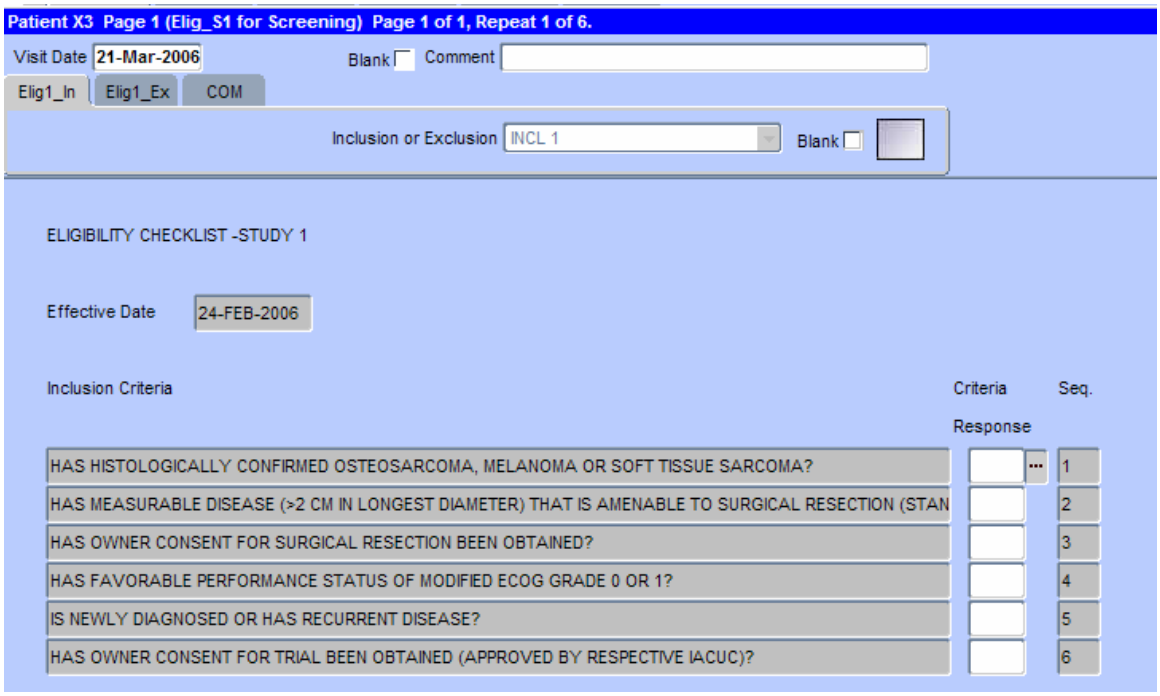
Purpose

Record the patient's status for each item of the eligibility checklist.

Each activated protocol has a customized eligibility checklist.

Eligibility Checklist eCRF

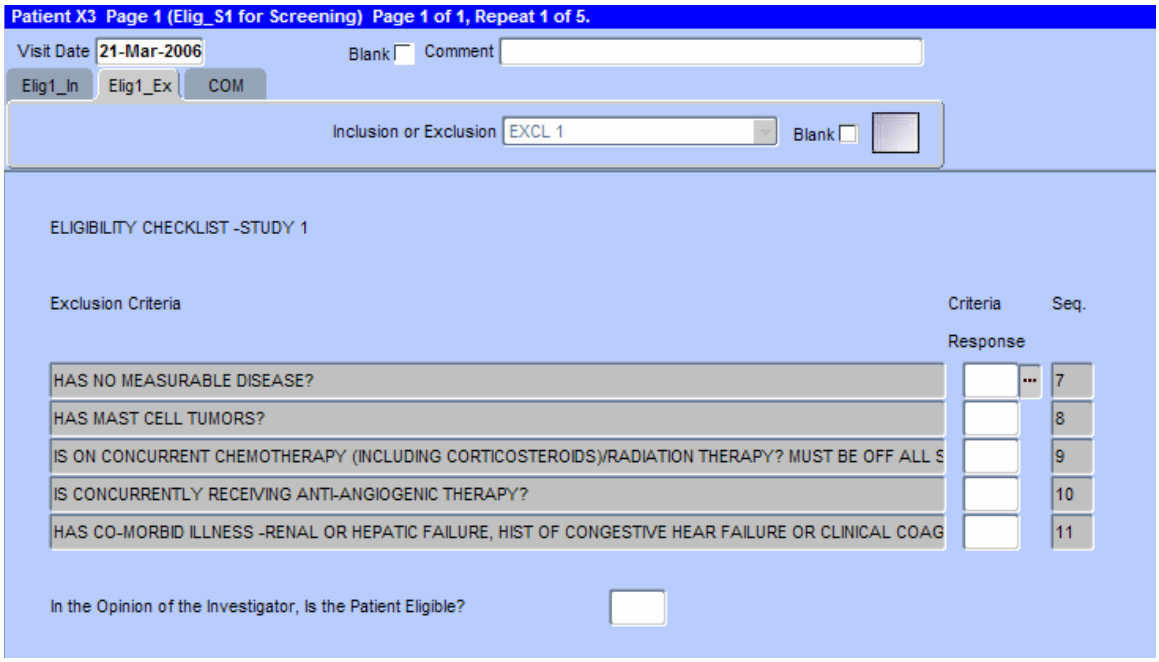
Inclusion Criteria tab (Study 1)



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Effective Date	Date of approval of the eligibility criteria. *Note: This field cannot be modified by the user.*	DD-MMM-YYYY
Criterion Response (m) ▪▪▪	Select the patient's status relative to the eligibility inclusion criterion. Y- Yes N- No X- Not Applicable *Note: Do not leave this field empty. Select one of the above responses.*	Use pick list.
Sequence	The inclusion criterion sequence number. *Note: This field cannot be modified by the user.*	2 digits
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

Eligibility Checklist eCRF

Exclusion Criteria tab (Study 1)



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Criterion Response (m) ...	Select the patient's status relative to the eligibility exclusion criterion. Y- Yes N- No X- Not Applicable *Note: Do not leave this field empty. Select one of the above responses.*	Use pick list.
Sequence	The exclusion criterion sequence number. *Note: This field cannot be modified by the user.*	2 digits
In the opinion of the investigator, is the patient eligible? (m) ...	Select the investigator's decision. Y- Yes N- No X- Not Applicable	Use pick list.
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(ELIGIBILITY-CHECKLIST)

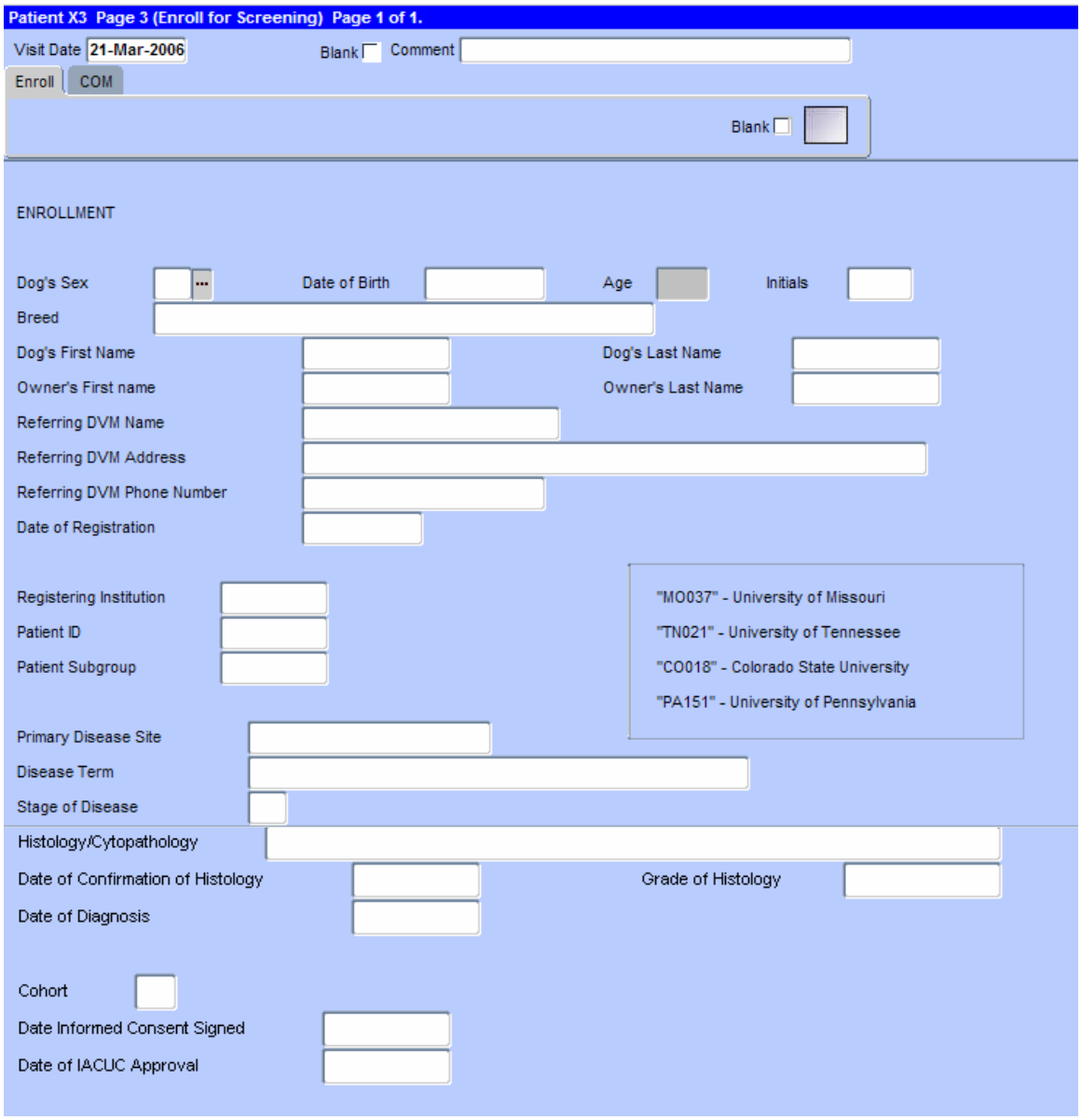
Enrollment

Purpose

Record the patient's enrollment information at the time of study entry.

Enrollment eCRF

Enrollment tab.



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the patient's registration date.	DD-MMM-YYYY
Dog's Sex (m)	Select the patient's gender: F- Female Intact M- Male Intact MC- Castrated Male SF- Spayed Female	Use pick list.
Date of Birth (m)	Enter the patient's date of birth. *Note: If the exact date is unknown use the first day of the birthday month as the DD.*	DD-MMM-YYYY
Age at Entry (d)	Age is derived from the patient's birth date at the enrollment and it remains the same throughout the study.	2 digits and 1 decimal
Patient Initials (d)	Derived as first letter of the first name and first letter of the last name	3 characters
Dog's First Name	Enter first name of dog	100 Characters
Dog's Last Name	Enter last name of dog	100 Characters
Owner's First Name	Enter Owner's first name	100 Characters
Owner's Last Name	Enter Owner's last name	100 Characters
Referring DVM Name	Enter full name of referring DVM	100 Characters
Referring DVM Address	Enter full address of referring DVM	150 Characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Referring DVM Phone Number	Enter Referring DVM's phone number	20 Characters
Date of Registration (m)	Enter the date when patient was registered to the study.	DD-MMM-YYYY
Registering Institution (m) ...	Enter the unique institution code where the patient was originally registered on study (e.g., institution where the patient signed the informed consent form). Refer to the code list in the text box to the right of the field	Use pick list.
Patient ID	Enter the patient's local identifier used by the treating institution.	12 characters
Patient Subgroup (c) ...	Select the appropriate study group the patient was enrolled to. Study 1 Study 2	Use pick list.
Primary Disease Site (m) ...	Select the primary disease site of the malignancy. If the primary site is unknown, state "UNKNOWN". If the diagnosis is leukemia, enter LEUKEMIA, not bone marrow. If the diagnosis is lymphoma, enter LYMPHOMA, not lymph nodes. Do not give detailed descriptions. For example, do not state "anterior tibial surface of the left leg", state only "leg". In the case of brain lesions, give the closest anatomical description of the originating site (e.g., frontal lobe).	Use pick list.
Disease Term (m) ...	Select a disease term.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Disease Stage at Entry ▪▪▪	Select the stage of the disease at the time of study entry, if appropriate. Leave it blank otherwise. 0 I I A I B I C II II A II B III III A III B III C IV IV A IV B *Note: See Appendix for WHO staging.*	Use pick list.
Histology / Cytopathology	State briefly the type of histology or cytopathology found at the time of original diagnosis. Be as descriptive as possible.	50 characters (40 reported)
Date of Confirmation of Histology	Enter the date when the patient's disease status was confirmed, at the treating institution, prior to study entry (if required by the protocol).	DD-MMM-YYYY
Grade of Histology	Enter the grade of histology at study entry, if appropriate. Leave it blank otherwise.	10 characters (4 reported)
Date of Diagnosis	Enter the first date of original diagnosis (e.g., when a positive biopsy or surgical result was obtained). Do not give the start date of symptoms as the date of diagnosis.	DD-MMM-YYYY or MMM-YY
Cohort (m) (c) ▪▪▪	Select the appropriate treatment cohort.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Date Informed Consent Signed (m)	Enter the date the patient signed the informed consent form.	DD-MMM-YYYY
Date of IACUC Approval (m)	Enter the IACUC approval date of the informed consent that the patient signed at the time of study entry. *Note: This is also the study initiation date: March 1, 2006.*	DD-MMM-YYYY
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only, (u) for CDUS reporting only.		

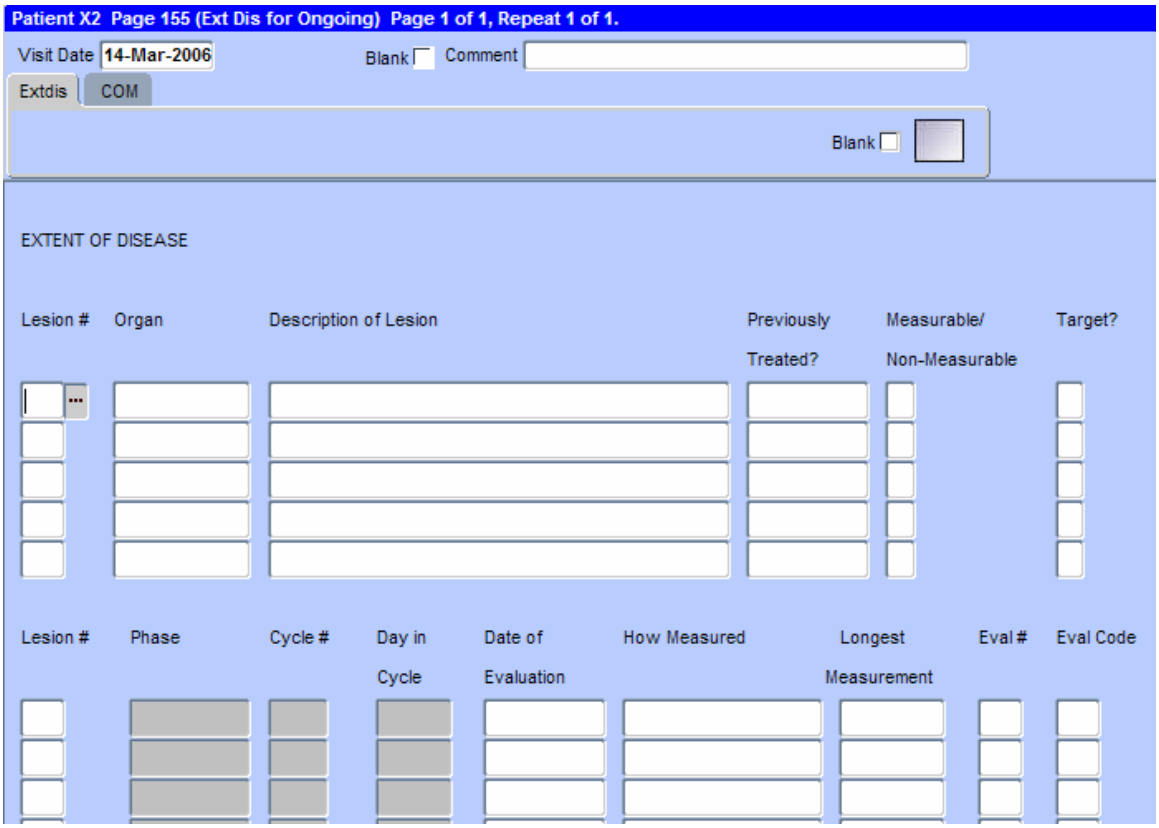
(ENROLLMENT)

Extent of Disease

Purpose

Record all sites of disease, even if they will not be followed for response.

Extent of Disease eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Lesion # field.	DD-MMM-YYYY
Lesion # (m) ...	Select a unique number for each lesion. Once a lesion number is designated for a specific lesion, that number may not change or be used to denote a different lesion. *Note: This lesion number must appear at least once on the bottom repeating group.*	Use pick list.
Organ (m) ...	Select the organ system where the lesion is located, i.e. Lung, Brain, etc.	Use pick list.
Description of Lesion (m)	Enter a brief description of the anatomical site of each lesion, e.g. right lobe.	32 characters
Previously Treated(m) ...	If the site or lesion has previously been Treated, enter "Y" for Yes, otherwise enter "N" for No.	Use pick list.
Measurable / Non-Measurable (m) ...	Enter "M", for measurable, " and "N" for non-measurable, as defined in the protocol.	Use pick list.
Target? (m) ...	Enter "Y" for target lesions that will be assessed for response (e.g. using the RECIST response criteria). Enter "N" for non target lesions.	Use pick list.
Lesion # (m)	Select a lesion number from the pick list. *Note: This lesion number must appear in the description section (top repeating group).*	Use pick list.
Phase (d)	Derived as ‘Study 1’ or ‘Study 2’.	10 Characters
Cycle # (d)	Indicates the cycle number that this lesion evaluation was done in as derived from the cycle initiation start date.	5 digits

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Day in Cycle (d)	Indicates the day since the beginning of cycle that this lesion evaluation was done as derived from the cycle initiation start date.	5 digits
Evaluation Date (m)	Enter the date of the evaluation (i.e.: date of CT scan). Do not enter the date of the report or when the results were received.	DD-MMM-YYYY
How Measured (m) ▪▪▪	Select how the lesion measurement was determined. The same method should be used to measure a specific lesion throughout the study. For example, if the measurements were determined by a chest x-ray, enter CXR.	Use pick list.
Longest Measurement (m)	Enter the longest lesion measurement in centimeters (for consistency with the RECIST criteria.)	3 digits and 2 decimals
Evaluation # (m)	Number each evaluation sequentially for each lesion. Use 0 for the baseline evaluation, 1 for the first evaluation, 2 for the second evaluation, etc.	2 digits
Evaluation Code ▪▪▪	Select the status of non-measurable lesions at the time of each evaluation. B- Baseline (use for the initial lesion evaluation that were when the treatment started.) D- Decreasing I- Increasing N- New (use for lesions that appear after treatment has started.) R- Resolved S- Stable	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

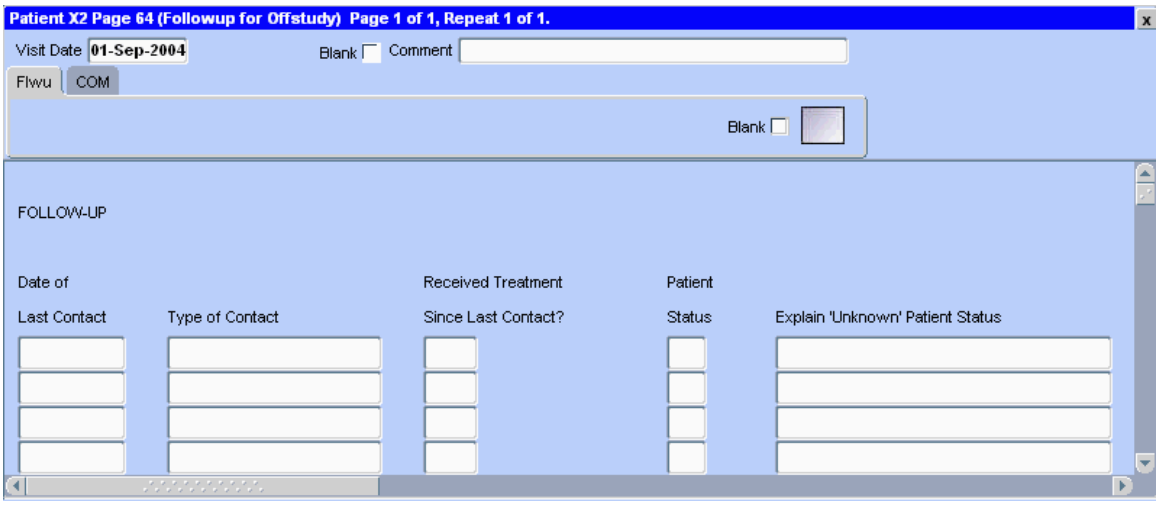
(EXTENT-OF-DISEASE)

Follow-up

Purpose

Record each follow-up contact as identified in the protocol.

Follow-up eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Date of Last Contact field.	DD-MMM-YYYY
Date of Last Contact (m)	Enter the date the patient was last contacted. If the patient is being considered lost to follow-up (i.e.: unsuccessful contact with the client/ rDVM), please indicate the date that no further follow-up will be attempted.	DD-MMM-YYYY
Type of Contact (m) ...	Select how the information was obtained: 12. Examination at VTH 13. Telephone contact with client 14. Telephone contact with patient's rDVM 15. Social Security Death Index (SSDI) 16. Mail contact with the client 17. E-Mail contact with the client	Use pick list.
Received Treatment Since Last Contact? (m) ...	If the patient has received further treatment since the last contact, select Y- Yes N- No	Use pick list.
Patient Status (m) ...	Select one of the options below that indicates the patient's last known status. If the patient has died, enter the date in the Date of Death field. If status is unknown, enter some explanation on the field labeled "Unknown (explain)". 1. Alive with disease 2. Alive with no evidence of disease 3. Alive disease status unknown 4. Unknown (Explain) 5. Died	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Explain 'Unknown' Patient Status	If Patient Status is unknown, enter some explanation here. Include what attempts were made and how many attempts where made in order to obtain the patient's status (i.e.: no response to 5 messages left).	24 characters
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(FOLLOW-UP)

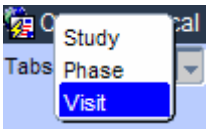
Labs

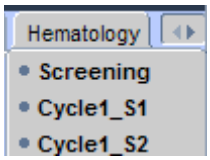
Purpose

Record the patient's lab results.

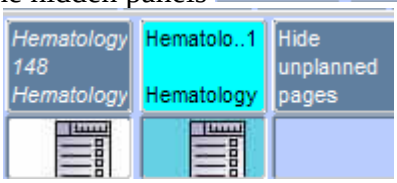
For normal bloodwork results, only IDEXX information will be entered into C3D. This will be done by the COP. Any other abnormal bloodwork recorded in-house (for Adverse Events) must be added as below.

To manually enter results in a lab panel, do the following:

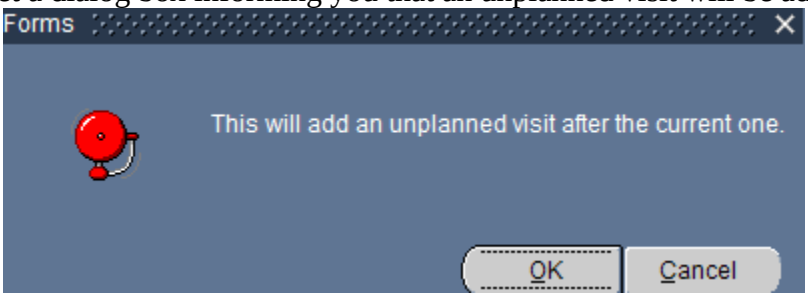
1. Select 'Visit' tab mode 

2. Click the double arrow, at the right of the screen, to select the desired lab panel 

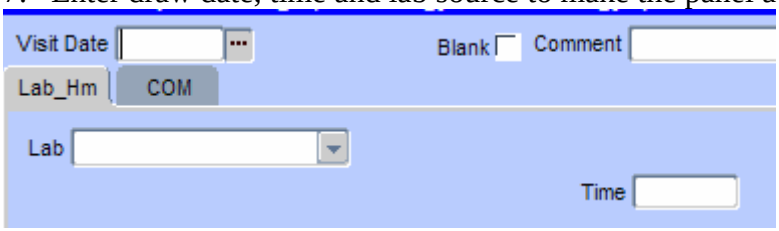
3. Click 'Show Unplanned Pages' to expand the hidden panels 

4. Open and close the last panel to highlight it 

5. Select **Insert/Visit** from the menu bar 

6. You will get a dialog box informing you that an unplanned visit will be added.
Click **OK** 

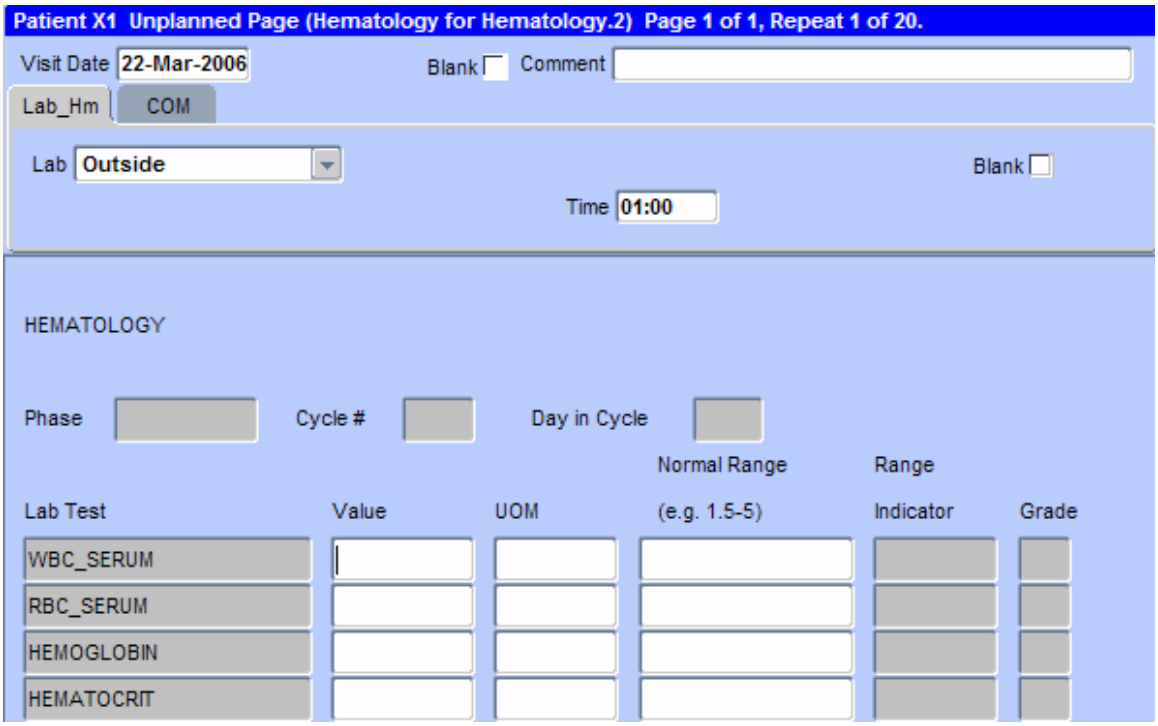
7. Enter draw date, time and lab source to make the panel available for data entry



The following lab CRFs are available. Following the field description section is a list of the lab tests.

- Hematology (includes CBC and coagulation profile)
- Blood Chemistry
- Urinalysis

Labs eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the lab sample was collected.	DD-MMM-YYYY
Time (m)	Enter the time the lab sample was collected. Enter midnight as 24:00 since 00:00 is used when time is not known.	HH(24):MM
Lab ...	Select the source of the lab results. Dlm- Lab results automatically loaded from another system. Dlm$Diabetic- Not in use. **Do not use.** Outside- Outside lab results entered manually. Respfunc- Not in use. **Do not use.**	Use pick list.
Phase (d)	Derived as 'Study 1' or 'Study 2'.	10 Characters
Cycle # (d)	Indicates the cycle number this lab is related to.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle this lab is related to.	5 digits
Lab Test (d)	Pre-defined name of the lab test. Each lab has a different set of tests which are listed at the end of this document.	20 characters
Value	Enter the lab test result value.	20 characters.
UOM ...	Select the appropriate lab test value units of measurement.	Use pick list.
Normal Range	For labs obtained outside of Idexx, enter the appropriate normal range.	30 characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Range Indicator (d)	Indicates how the lab result value compares to the lab test normal range. NORMAL- Falls within the normal range. HIGH- Above the normal range. LOW- Below the normal range. NONNUM- Not a valid number (e.g. "No Data"). NORANG- No normal values are provided.	6 characters
Grade	Enter the lab grade according to the VCOG-CTCAE.	13 characters
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

Lab Tests		
Lab	**Test**	**Description**
HEMATOLOGY	WBC_SERUM	WBC, Blood
	RBC_SERUM	RBC, Blood
	HEMOGLOBIN	Hemoglobin, Blood
	HEMATOCRIT	Hematocrit, Blood
	MCV	MCV, Blood
	MCH	MCH, Blood
	MCHC	MCHC, Blood
	NEUT	Neutrophils, %, Blood
	BANDS	Bands, #, Blood
	LYMPHOCYTES_SERUM	Lymphocytes, %, Blood
	MONOCYTES_SERUM	Monocytes, %, Serum
	EOSIN	Esoinophils, %, Blood
	BASO	Basophils, #, Blood

Lab Tests		
Lab	**Test**	**Description**
	ANC	Neutrophil Count, #, Blood
	LYMPHOCYTES_ABS	Lymphocytes, #, Blood
	MONOCYTES_ABS	Monocytes, #, Blood
	EOSIN_ABS	Eosinophils, #, Blood
	BASO_ABS	Basophils, #, Blood
	PLT	Platelets, Blood
	PT	PT, Automated, Blood
	PTT	PTT, Automated, Blood
BLOOD CHEMISTRY	ALK_PHOS	Alkaline Phosphatase, Serum
	SGPT_ALT	SGPT/ALT, Serum
	SGOT_AST	SGOT/AST, Serum
	CPK	Creatine Kinase, Serum
	LDH	Lactate Dehydrogenase, Serum
	SGGT	GGT, Serum
	AMYLASE_SERUM	Amylase, Serum
	LIPASE_SERUM	Lipase, Serum
	GLOBULIN	Globulin, Serum
	ALBUMIN_SERUM	Albumin, Serum
	TOT_PROT	Protein, Serum
	BILIRUBIN_TOTAL	Bilirubin, Total, Serum
	BILIRUBIN_DIRECT	Bilirubin, Direct, Serum
	BUN	Blood Urea Nitrogen, Serum
	CREATININE	Creatinine, Serum
	CHOLESTEROL_TOTAL	Cholesterol, Total, Serum
	GLUC_SER	Glucose, Serum (Fasting status not specified)
	CALCIUM	Calcium, Serum
	INORG_PHOS	Phosphorus, Inorganic, Serum
	BICARB_SERUM	Bicarbonate, Serum
	CHLORIDE	Chloride, Serum

Lab Tests		
Lab	**Test**	**Description**
	POTASSIUM	Potassium, Serum
	URIC_ACID	Uric Acid, Serum
	SODIUM	Sodium, Serum
	MAGNESIUM	Magnesium, Serum
	TRIGLYCERIDES	Triglycerides, Serum
	SORB_DEHYDROG_SER	Sorbitol Dehydrogenase, Serum
Urinalysis	QUALITATIVE_PROTEIN	Protein, Urine
	QUALITATIVE_GLUCOSE	Glucose, Urine
	KETONES	Ketones, Urine
	BLOOD	Blood, Urine
	UROBILINOGEN	Urobilinogen, Urine
	LEUKOCYTE_ESTERASE	Leukocyte Esterase, Urine
	NITRITE	Nitrite, Urine
	PH_URINE	pH, Urine
	SPECIFIC_GRAVITY	Specific Gravity, Urine
	RBC_URINE	RBC, Micro, Urine
	WBC_URINE	WBC, Micro, Urine

Off Study

Purpose

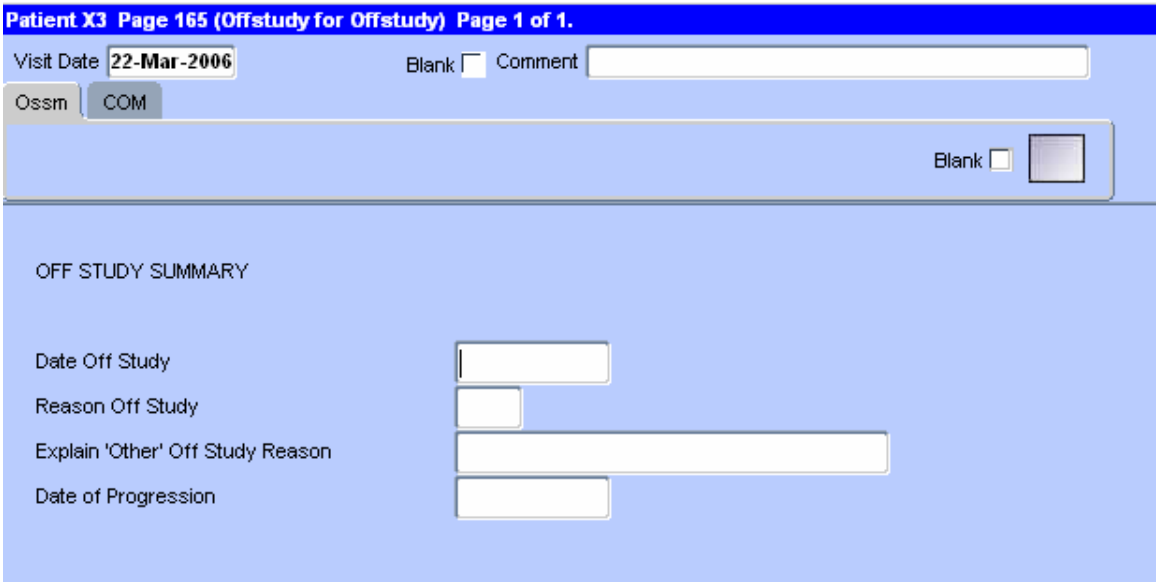
Record information concerning the patient's off study date and reason. Complete this form after the patient has been taken off study.

For studies without a protocol specified follow-up period, this form is completed when the patient is taken off treatment. The off study date, reason and explanation must be the same as the off treatment case report form date off treatment, reason and explanation respectively.

For studies with a protocol specified follow-up period, this form is completed when all follow-up time points and data have been collected as specified in the protocol or if the patient dies within the follow-up period or if follow-up period ends for any other reason. If the off treatment reason prevents the follow-up period from occurring, then the off study date, reason and explanation must be the same.

No further data will be collected once this form is completed.

Off Study eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form is being completed.	DD-MMM-YYYY
Date Off Study (m)	For protocols with a specific follow-up period, enter the date that corresponds to the date when all protocol specific follow-up has been completed. For protocols without a protocol specific follow-up, enter the date that the patient came off treatment, i.e. cycles have been completed (including the normal observation period) or discontinued and no further treatment cycles are planned. **This date must be the same as the Date Off Treatment entered on the Off Treatment case report form**. The date off study will correspond to a progress note in the medical record stating that the patient has been taken off study.	DD-MMM-YYYY
Reason Off Study (m)	For protocols without a protocol specific follow-up, **use the same 'Reason Off Treatment' entered on the Off Treatment case report form**. For protocols with a follow-up period, the following off study reasons are also available. **Y-** Completed treatment period but refused the Protocol-Specified Follow-up. Date Off Treatment and Date Off Study must be the same. **H-** **Follow-up Period Completed**: The patient completed all protocol specified follow-up evaluations. **L-** **Lost to Further Follow-up**: Follow-up information could not be obtained because contact with the patient was lost. Every effort to locate patient needs to be considering including: contact with client, rDVM, etc. **W-** **Refused Further Follow-up**: The client has refused to have any further follow-up	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
	evaluations. **M- Death during Follow-up Period**: The patient died during the follow-up phase of the protocol. The Date Off Study must coincide with the date of death (located on the Survival case report form). **J- Disease Progression during Follow-up Period**: The patient was taken off study for disease progression during the follow-up period. **A Date of Progression must be entered.** **K- Other Reasons**: Other reasons may be given for taking the patient off study. Enter an explanation in the "Explain 'Other' Reason" field.	
Explain 'Other' Reason	Enter an explanation for selecting "Other" for a Reason Off Study. For protocols without a protocol specific follow-up, **repeat the same explanation entered on the Off Treatment case report form**.	24 characters
Date of Disease Progression	If disease progression is selected as the reason the patient came off study, enter the date the disease assessment (i.e.: CT scan) was performed.	DD-MMM-YYYY
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(OFF-STUDY)

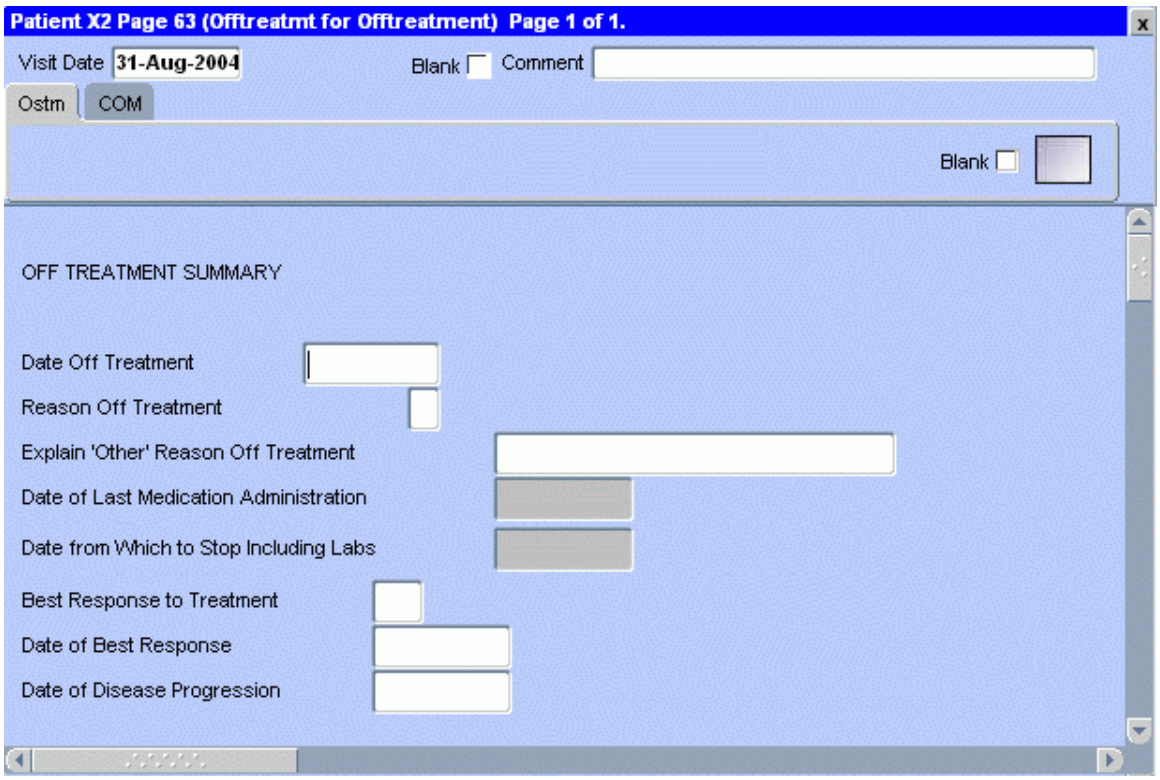
Off Treatment

Purpose

Record information concerning the patient's off treatment date, reason and best response to treatment.

For studies without a protocol specified follow-up period, also complete the Off Study case report form entering the same Date, Reason and, if applicable, the Reason Explanation and Date of Disease Progression. Also complete the Off Study form with the same information when the Reason Off Treatment prevents the follow-up period from occurring.

Off Treatment eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form is being completed.	DD-MMM-YYYY
Date Off Treatment (m)	Enter the date when all cycles have been completed (including the normal observation period) or discontinued and no further treatment cycles are planned. This date will correspond to the clinic visit that would have served as the pre-cycle visit had the patient continued on therapy. This is the date the patient has been officially taken off treatment.	DD-MMM-YYYY
Reason Off Treatment (m) ...	Select an off treatment reason from one of the following reason groups: 1) If the patient's participation has been completed as per protocol, and the protocol does not specify a follow-up observation period, select: **C- Study Completed** *Note: Option 'C' is only available for studies without a follow-up period.* 2) For patients who were evaluated for entry to the protocol and signed an informed consent form, but were not treated (never received any drugs or therapies per the protocol), select one of the following: **X- Client Declined to Participate** (before treatment started.) **B- Disease Progression before Treatment.** **Z- No Treatment, per protocol.** **U- Not Treated - Other Reasons, explain** - Enter an explanation in the Reason Other field. 3) When the patient's participation terminated during treatment period, select one of the	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
	following: **P- Disease Progression On Study**: The patient was taken off treatment for disease progression. This must be reflected by an increase in the non-measurable or measurable disease state. (See Cycle Assessment and Extent of Disease Forms). This can be manifested as clinical deterioration. **A Date of Progression must be entered.** **D- Death During Treatment**: The patient has died during the treatment phase. The cause of death should be listed on the Survival case report form and, if applicable, on the Adverse Events case report form as well. **T- Adverse Events / Side Effects**: The patient experienced any toxicity that was considered related to the study medication, which prohibited further protocol treatment. Patients discontinued due to toxicity are evaluable provided the observation period has been completed per protocol. The toxicity must be listed on the Adverse Events form. **S- Complicating Disease / Intercurrent Illness:** Patient was taken off treatment due to complicating disease not related to malignancy. This should be included in the Adverse Event form by an event not considered to be related to therapy. **G- Cytogenetic Resistance.** **A- Switched to Alternative Treatment:** The patient was taken off treatment due to a decision to pursue alternative therapy (such as palliative radiation)**.** **R- Refused Further Treatment:** If at any time the patient refused further treatment. **I- Late Determination of Ineligibility:**	

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
	Patient was taken off treatment following treatment because follow-up tests indicate that patient was not eligible for the study. **V- Protocol Violation:** If a major protocol violation has occurred, the reason must be stated in the Comments part of this case report form. **O- Other:** Other reasons may be given for taking the patient off treatment, although they may not be included in the protocol stipulated rules. The patient's evaluability will subsequently be determined. Enter an explanation in the Reason 'Other' field. 4) When the patient completes protocol-specified treatment period, select the following: **Q- Treatment Period Completed** *Note: Option 'Q' is only available for studies with a follow-up period.*	
Explain 'Other' Reason Off Treatment	Enter an explanation for selecting "Other" for a Reason Off Treatment.	24 characters
Date of Last Medication Administration (d)	Indicates date the last medication was administered.	DD-MMM-YYYY
Best Response to Treatment (m)	Select the best overall response to treatment while on protocol. CR- Complete Response MR- Minor Response PD- Progressive Disease SD- Stable Disease SS- Significant Stabilization NA- Not Assessed - State the reason in the	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
	"Response Note" field. NP- Protocol does not require a response assessment during the specific cycle. TE- Too Early to confirm a response. According to RECIST and WHO guidelines this would be the best response assessed from the start of treatment until disease progression. Ordinarily this would be the best of the responses reported on the cycle assessment CRFs. For example, do not enter "SD" if the patient was assessed only with progressive disease. **Please be sure to enter the best response, not necessarily the response on the last cycle.** For example, if the patient was assessed with a PR followed by a PD, enter the "PR". If response was not assessed at all during the protocol treatment, enter the best response as NA; similarly for NE and NP. RECIST: Unless the protocol includes specific response evaluation criteria, the following RECIST and WHO guidelines should be observed: Responses of PR and MR are assessed relative to the baseline at start of treatment, not to previous cycles. They must be confirmed by repeat assessments. Subsequent evaluations at which tumor sizes are substantially unchanged should be assessed again as the same PR/MR. A response of PD is relative to the best disease status (smallest tumor measurement) since treatment began. Thus a tumor re-growth after a	

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
	PR would be assessed as PD not an MR. A PR or MR cannot follow a CR.	
Date of Best Response	Enter the date that a Best Response of Treatment response of CR, PR, or MR was first observed, or that an SD response began. This date must be consistent with the date entered on the Cycle Assessment case report form(s) and with evaluations on the Extent of Disease Form.	DD-MMM-YYYY
Date of Disease Progression	Enter the date that progression (or relapse) was first observed (i.e.: date of scan). **This date is required if the Reason for Off Treatment is for Disease Progression.** This date must be consistent with the date of progression entered on the Cycle Assessment form(s) and with evaluations on the Extent of Disease Form. Progression is the worsening of disease following a period of stable disease or a response. Relapse is the reoccurrence of disease in a patient with no evaluable disease at enrollment (e.g. on an adjuvant treatment study).	DD-MMM-YYYY
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(OFF-TREATMENT)

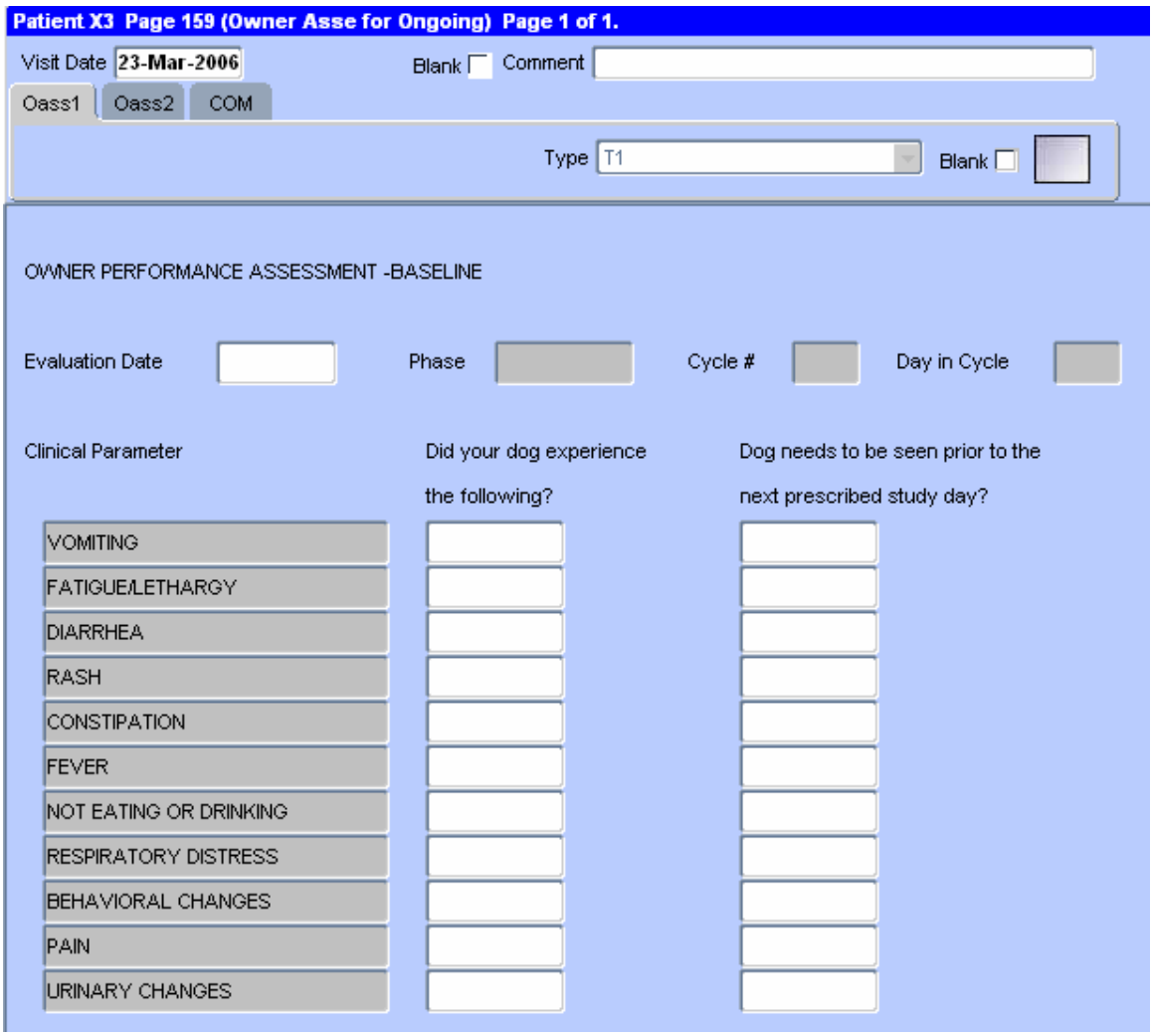
Owner's Assessment

Purpose

Determine the owner/client's assessment of the health of their pet while not observed at the hospital.

The paper CRF should be given to the client both at discharge on Day 1 and after surgery. The first form would be returned on Day 4 (defined as interval between agent administration and surgery-**TAB 1**) and the latter returned at suture removal (defined as interval between surgery and follow up-**TAB 2**). The data should then be entered into the eCRF based upon the paper CRF the client has completed.

Owner's Assessment eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Evaluation Date (m)	Enter the date the form was collected from the client.	DD-MMM-YYYY
Phase (d)	Derived as 'Study 1' or 'Study 2'	10 Characters
Cycle # (d)	Indicates the cycle number the procedure is related to based on their date and time.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle the procedure is related to based on their date and time. *(e.g. Day 4 or Day 14)*	5 digits
Did your dog experience the following? ▪▪▪	For each of the Clinical Parameters, select from the following options: Yes No Unknown	Use pick list.
Dog needs to be seen prior to the next prescribed study day?▪▪▪	For each of the Clinical Parameters, select from the following options: Yes No Unknown	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(OWNER'S ASSESSMENT)

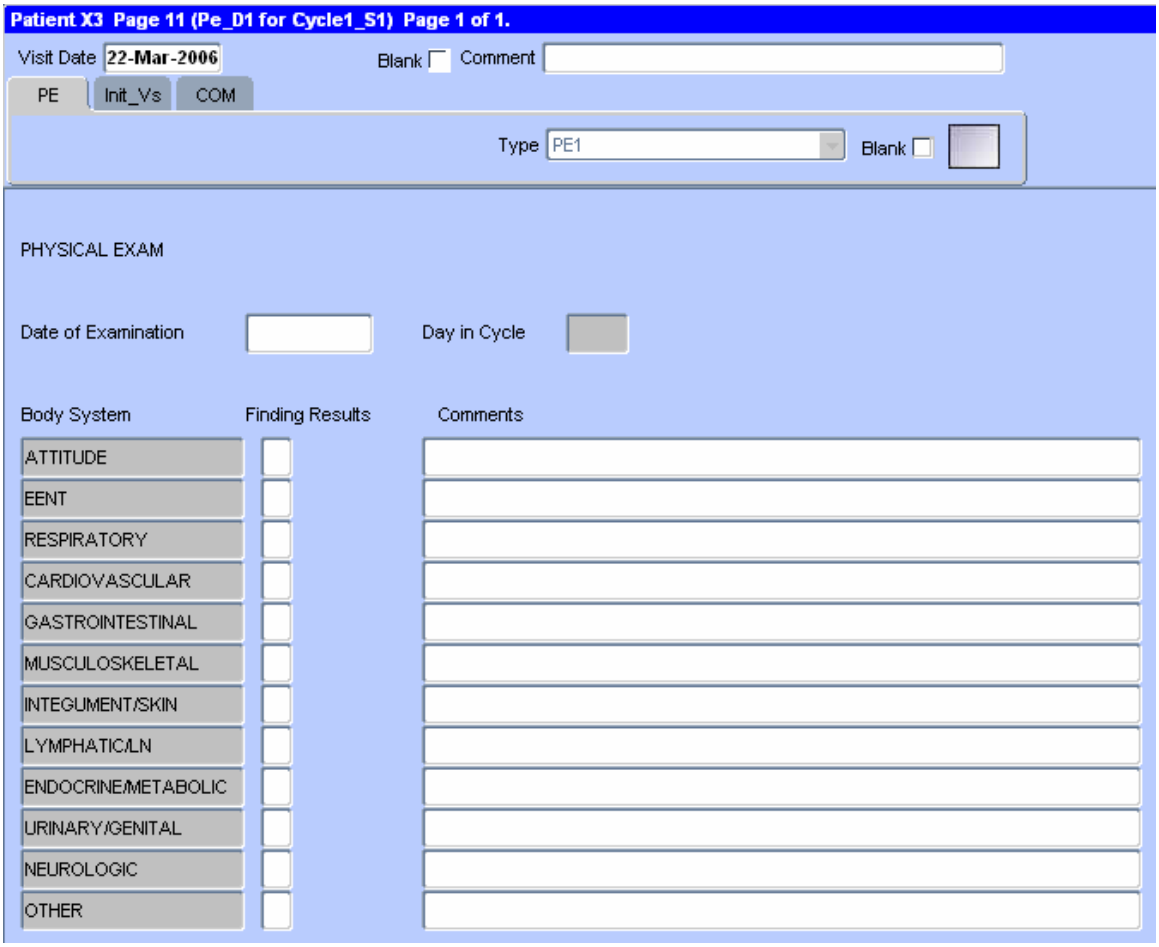
Physical Exams – Screening and Cycles

Purpose

Screening - Record baseline physical exam results.
Cycles - Record follow-up physical exam results.

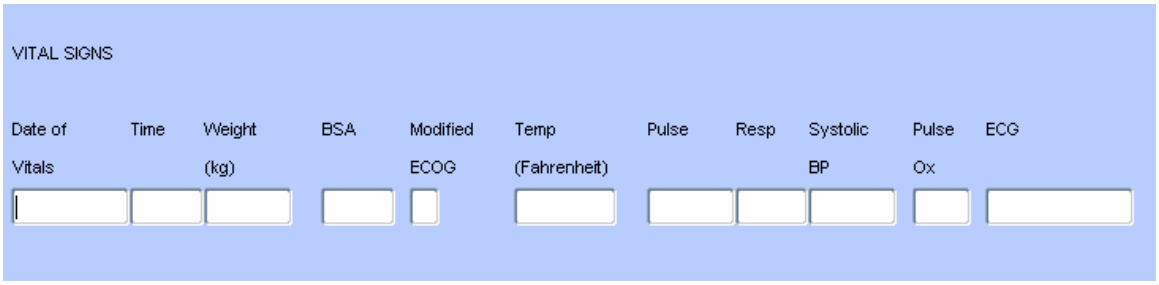
Note: For study 1 a cycle is the entire study period whereas in study 2 a cycle would be four (4) administrations of phage.

Physical Exams tab - eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the physical examination took place.	DD-MM-YYYY
Date of Examination (m)	Enter the date the physical examination took place.	DD-MM-YYYY
Day in Cycle (d)	Number of days since the beginning of the cycle is derived from the cycle initiation start date and examination date.	5 digits
Finding Results (m) ...	Indicate whether the finding results for the particular body system were either: N- Normal A- Abnormal X- Not Examined Comments are required for abnormal finding results. *Note: Do not select "Normal" if the body system was not specifically assessed during the physical exam (i.e., not mentioned in the progress note in the medical record).* Any baseline body system with "Abnormal" Finding Results that remained unchanged must be re-entered in this case report form.	Use pick list.
Comments	If the finding results of a particular body system has changed from baseline, give a brief description of the change. If choosing "Other", indicate the body or organ system missing from the list in the comment and include this for subsequent exams.	200 characters
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

Vital Signs tab.



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Date of Vitals (m)	Enter the date the vital signs were taken.	DD-MMM-YYYY
Time	Enter the time the vital signs were taken.	HH(24):MM
Weight	Enter the patient's weight only in kilograms.	3 digits and 2 decimals
BSA	Enter the patient's body surface area in m^2 (to two decimal places) if needed for the calculation of study medication dose level.	1 digit and 2 decimals
Performance Status – Modified ECOG	Select a value from the Karnofsky performance status scale. (*see protocol Appendix*) 0 - Normal activity 1 - Restricted activity; decreased activity from pre-disease status 2 - Compromised; ambulatory only for vital activities; consistently defecates and urinates in acceptable areas 3 - Disabled; must be force fed; unable to confine urination and defecation to acceptable areas 4 - Dead	Use pick list.
Temperature (Fahrenheit)	Enter the patient's temperature only in Fahrenheit, to one decimal place.	4 digits and 3 decimals

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Pulse	Enter the patient's pulse rate.	4 digits and 3 decimals
Respiration Rate	Enter the patient's respiration rate.	4 digits and 3 decimals
Systolic Blood Pressure	Enter the patient's systolic blood pressure (Doppler measurements are acceptable).	4 digits and 3 decimals
Pulse Oximetry	Enter the patient's pulse oximetry reading. *(if applicable via study protocol).*	3 digits
ECG	Enter the patient's ECG reading (Lead II strip).	8 Characters
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

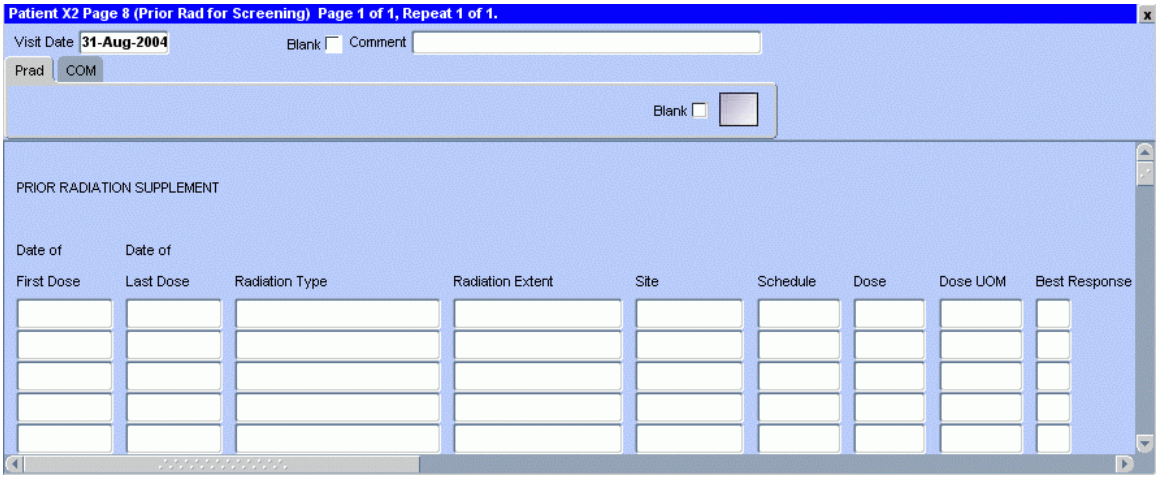
(PHYSICAL-EXAMS-SCREENING AND CYCLES)

Prior Radiation Supplement

Purpose

Record details of prior radiation therapy when specified by the protocol or when the details would be clinically significant for the evaluation of this study.

Prior Radiation Supplement eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed. *Note: If the information was obtained at multiple visits, please enter the date the form was completed.*	DD-MMM-YYYY
Date of First Dose (m)	Enter the date of the first dose of the radiation therapy. Partial dates are acceptable when the day is not known.	DD-MMM-YYYY or MMM-YYYY

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Date of Last Dose (m) ...	Enter the date of the last dose of the radiation therapy. Partial dates are acceptable when the day is not known. If the date of last dose is not available, select: Ongoing- if the therapy is currently being received.	DD-MMM-YYYY, MMM-YYYY or Use pick list.
Radiation Type (m) ...	Select the type of radiation therapy, e.g.: "proton beam", "external beam" or "implant".	Use pick list.
Radiation Extent (m) ...	Select the extent of the radiation therapy as follows: LR- Limited Radiation: palliative therapy using ionizing radiation. ER- Extensive Radiation: full course/curative intent therapy using ionizing.	Use pick list.
Site (m) ...	Select the site of the radiation therapy.	Use pick list.
Schedule ...	Select the radiation therapy schedule on which it was given.	Use pick list.
Radiation Dose	State the total radiation dose the patient received during the treatment period.	8 characters
Radiation Dose UOM ...	Select the radiation dose units of measurement (e.g. cGy or rad, or cSv or rem).	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Best Response (m) ▪▪▪	Select the best response for the irradiated lesion: CR- Complete Response PR- Partial Response MR- Minimal/Marginal Response SD- Stable Disease PD- Progressive Disease AJ- Adjuvant Therapy PA- Palliative Therapy NE- Not Evaluable NA- Not Assessed UK- Unknown	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

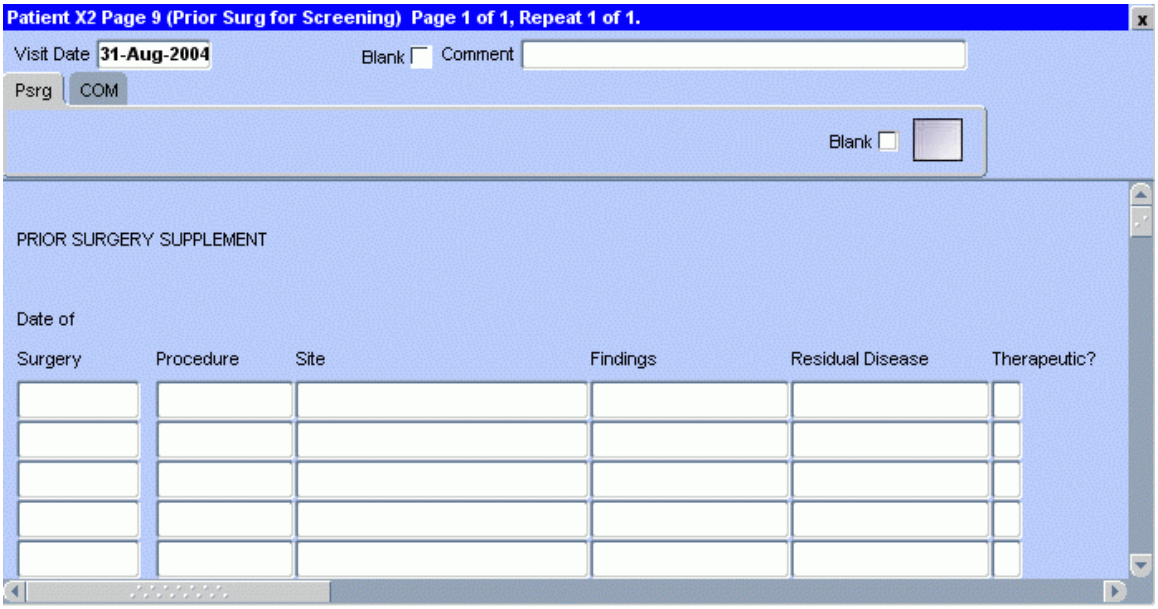
(PRIOR-RADIATION-SUPPLEMENT)

Prior Surgery Supplement

Purpose

Record details of prior surgery when required by the protocol or when the details would be clinically significant for the evaluation of this study.

Prior Surgery Supplement eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed. *Note: If the information was obtained at multiple visits, please enter the date the form was completed.*	DD-MMM-YYYY
Date of Surgery (m)	Enter the date of the surgical procedure. Partial dates are acceptable when the day and/or month are not known.	DD-MMM-YYYY, MMM-YYYY or YYYY

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Procedure (m)	Enter the type of procedure performed to diagnose / to treat the patient's disease. Examples include, but not limited too: biopsy, node dissection, cytology, bone marrow biopsy, FNA (fine needle aspiration).	24 characters
Site (m) ...	Select the anatomical site of the procedure.	Use pick list.
Findings	Briefly describe the findings of the procedure.	24 characters
Residual Disease	Briefly describe the extent of the residual disease, if any, at the conclusion of the operation. (i.e.: microscopic, macroscopic).	24 characters
Therapeutic? (m) ...	Select if the surgical procedure was performed with curative intent: Y- Yes N- No	Use pick list.
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

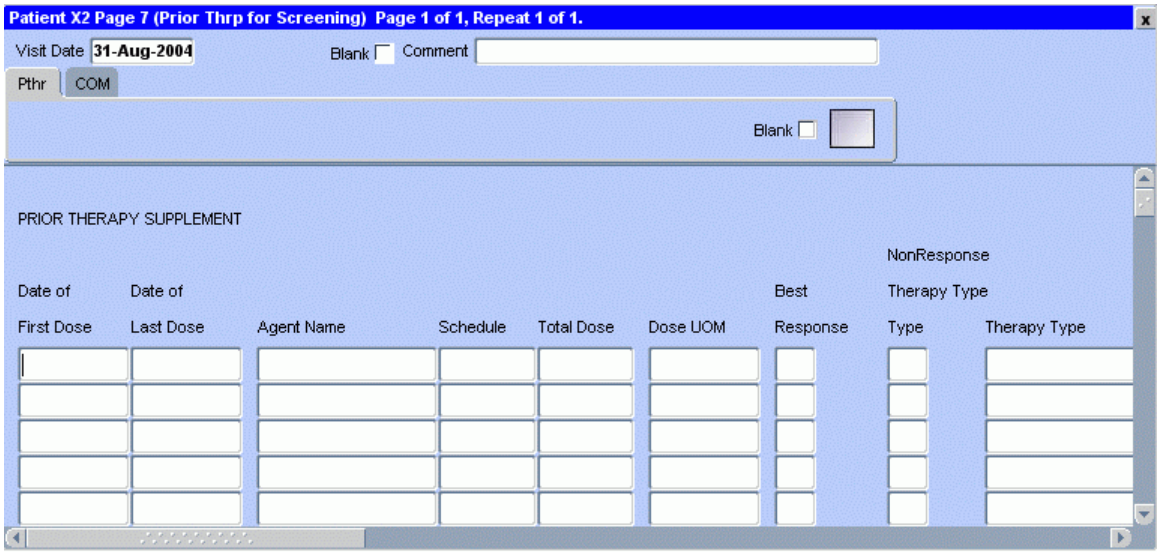
(PRIOR-SURGERY-SUPPLEMENT)

Prior Therapy Supplement

Purpose

Record details of prior therapies when specified by the protocol or when the details would be clinically significant for the evaluation of this study as indicated on the Prior Treatment Summary case report form.

Prior Therapy Supplement eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Date of First Dose (m) ...	Enter the date of the first dose of the prior therapy. Partial dates are acceptable when the day is not known.	DD-MMM-YYYY or MMM-YYYY

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Date of Last Dose (m) ▪▪▪	Enter the date of the last dose of the prior therapy. Partial dates are acceptable when the day is not known. If the date of last dose is not available, select: Ongoing- if the treatment is currently being received.	DD-MMM-YYYY, MMM-YYYY or Use pick list.
Agent Name (m) ▪▪▪	Select the generic name of the agent that was used. In the case of a standard regimen of multiple agents, the conventional abbreviation for the regimen (i.e., MOPP, CHOP, COP, etc.) may be used.	Use pick list.
Schedule ▪▪▪	Select the schedule on which the agent (or combination) was given.	Use pick list.
Total Dose	Enter the total dose of the agent. If a combination regimen, record the total dose of the relevant agent (e.g. doxorubicin in CHOP).	8 characters
Total Dose UOM ▪▪▪	Enter the total dose units of measurement.	5 digits
Best Response (m) ▪▪▪	Select the best response encountered: CR- Complete Response MR- Minor Response PD- Progressive Disease SD- Stable Disease SS- Significant Stabilization NA- Not Assessed - State the reason in the "Response Note" field. NP- Protocol does not require a response assessment during the specific cycle. TE- Too Early to confirm a response.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Therapy Type (m) ▪▪▪	Select the appropriate type of prior therapy: Chemotherapy multiple agents systemic Chemotherapy non-cytotoxic Chemotherapy single agent systemic Corticosteroids Gene Transfer Immunotherapy NSAIDS Vaccine	Use pick list.
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

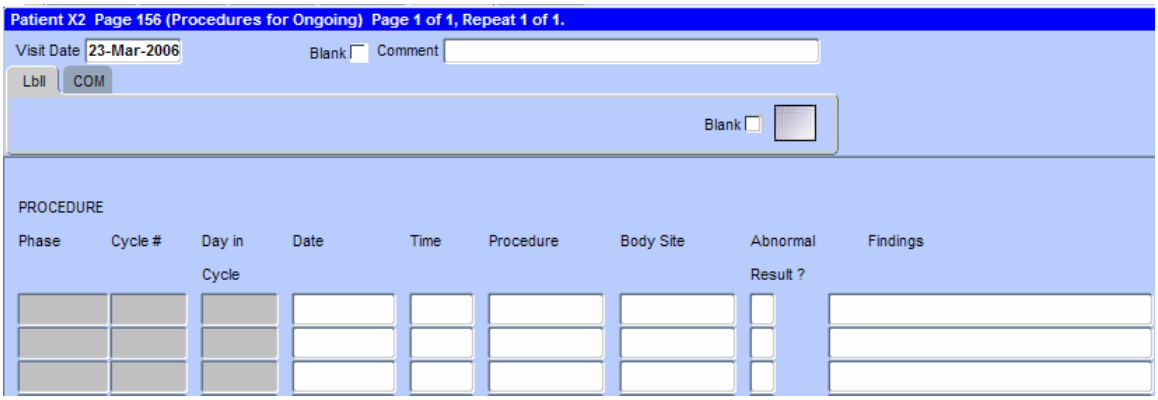
(PRIOR-THERAPY-SUPPLEMENT)

Procedures

Purpose

Record the results of the procedures that are performed as part of the protocol. All laboratory results are to be recorded on the appropriate lab CRF. All procedures that are done as a result of an adverse event are to be recorded on the concomitant measures CRF

Procedures eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Date field.	DD-MMM-YYYY
Phase (d)	Derived as ‘Study 1’ or ‘Study 2’	10 Characters
Cycle # (d)	Indicates the cycle number the procedure is related to based on their date and time.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle the procedure is related to based on their date and time.	5 digits
Date (m)	Enter the date that the procedure was done, not the date it was interpreted by the radiologist or investigator.	DD-MMM-YYYY
Time	Enter the time the procedure was done.	HH(24):MM

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Procedure (m) ...	Select the procedure from the pick list.	Use pick list.
Body Site (m) ...	Select the body site from the pick list. In the case of tests such as CATSCAN, MRI, and X-RAY record the applicable body site. For CAT Scan and MRI use thorax, abdomen, pelvis or brain.	Use pick list.
Abnormal Result ? (m) ...	Select whether the finding results for the particular procedure / body site were either: A- Abnormal N- Normal	Use pick list.
Findings	If abnormal, enter as summary of the abnormal findings.	128 characters
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(PROCEDURES)

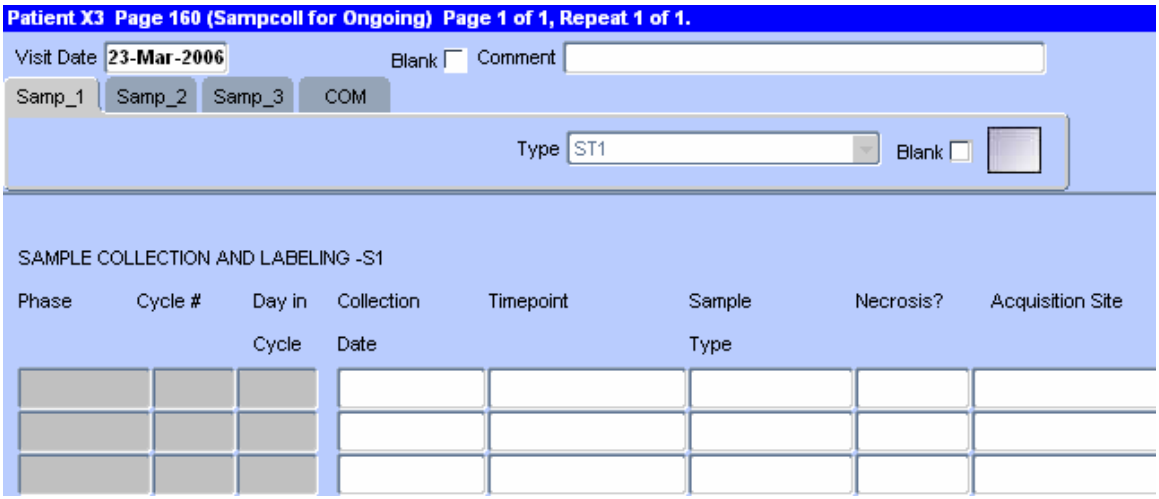
Sample Collection and Labeling

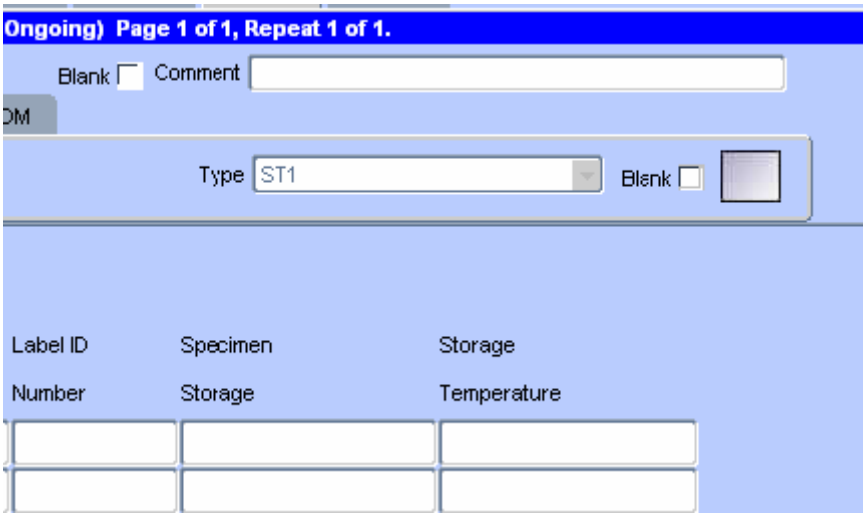
Purpose

Identify and describe all samples collected for this study.

This would involve tissue (tumor and normal), serum, plasma and blood collection. Storage method (OCT, RNAlater and formalin) as well as temperature are captured on this eCRF. Refer to the paper CRF for assistance in completing this form. The appropriate tissue location and barcode label must be included. There are several tabs available in case extra space is required.

Sample Collection and Labeling eCRF





Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the form was completed (i.e. the date information was gathered).	DD-MMM-YYYY
Phase (d)	Derived as 'Study 1' or 'Study 2'	10 Characters
Cycle # (d)	Indicates the cycle number the procedure is related to based on their date and time.	5 digits
Day in Cycle (d)	Indicates the day since the beginning of cycle the procedure is related to based on their date and time.	5 digits
Collection Date	Enter the date the sample was collected.	DD-MMM-YYYY
Timepoint ...	Select study time point for the collected sample: Day 0 Day 1 Day 4 Day 7 Day 14 Day 21 Day 28 Pre-Treatment (other) Post-Treatment (other) Necrosis (sample unevaluable)	Use pick list
Sample Type	Select sample type: Serum Tumor Tissue Plasma Whole Blood Normal Tissue	Use pick list
Necrosis?	Respond to the question of whether there was necrosis observed in the sample. Select from the following responses: Yes No Unknown	Use pick list
Acquisition Site	Add anatomic location description for each collected sample.	200 characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Label ID Number	All labels included in study materials, cross reference paper CRF.	15 characters
Specimen Storage	Indicate the specimen storage method. Select from the following options: Ehtanol-Fixed Fixed & Paraffin-Embedded Formalin-Fixed OCT-Frozen Other Snap-Frozen RNALater	Use pick list
Storage Temperature	Select the temperature the specimen was stored at: -20 degrees Celsius -80 degrees Celsius 4 degrees Celsius Room temperature	Use pick list
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(SAMPLE COLLECTION AND LABELING)

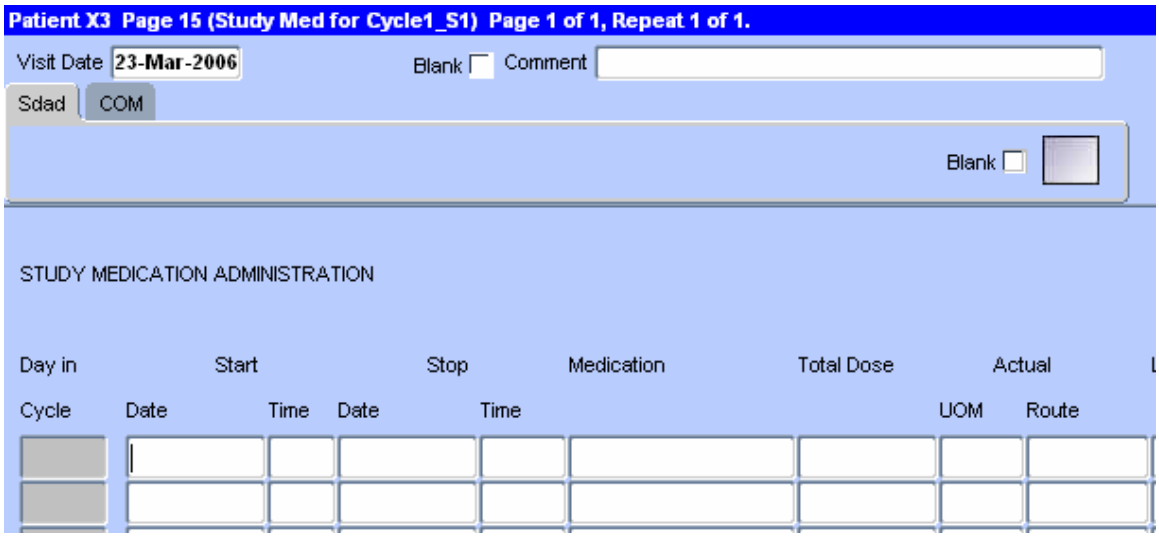
Study Medication Administration

Purpose

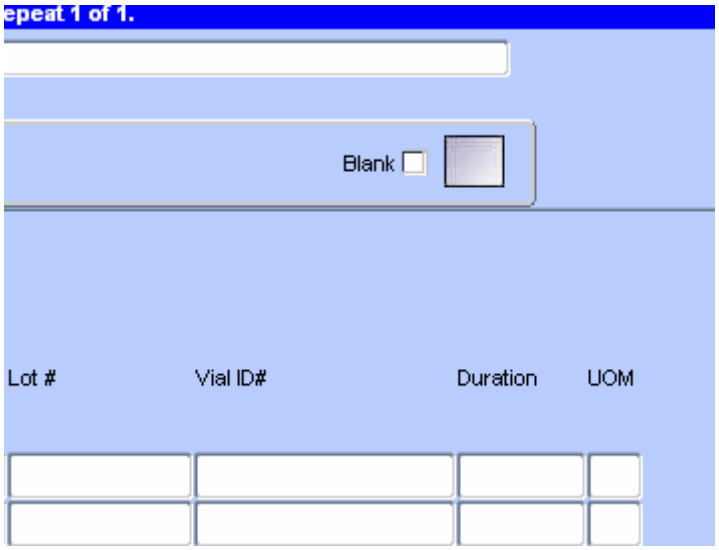
Record medication administration. Use a separate line for each medication.

Study Medication Administration eCRF

Study Medication Administration Tab



The following screen shot is the portion to the right of the Planned Route field.



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date (m)	Enter the date the cycle started.	DD-MMM-YYYY
Day in Cycle (d)	Indicates the day since the beginning of cycle initiation. Derived from the cycle initiation start date.	5 digits
Start Date (m)	Enter the date the medication was administered.	DD-MMM-YYYY
Start Time	For IV infusions only: Enter the start time of the infusion.	HH(24):MM
Stop Date	Enter the date the medication was discontinued.	DD-MMM-YYYY
Stop Time	For IV infusions only: Enter the stop time of the infusion.	HH(24):MM
Medication (m) ...	Select a medication from the list. *Note: The medication pick list incorporates all study medications, including pre and post medications specified in the protocol as part of the treatment. These medications should be documented in this case report form and not in the Concomitant Measures / Medications form.*	Use pick list.
Actual Dose (m)	Enter the total actual dose given for the medication name entered above for the time period encompassed by the duration. See Actual UOM below for the units of measure of the actual dose. Note: In the case of medications (such as vaccines and viral particles) where the dose is expressed with scientific exponential units using powers of 10, record (for example) 10^6 as 1X10E6.	8 characters
Actual Dose UOM (m) ...	Select the Actual Dose Level unit of measurement.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Route (m) ...	Select the route given: **IM**- intramuscular **ID**- intradermal **IV**- intravenous bolus (less than 30 minutes) **IVI**- intravenous infusion (greater than 30 minutes, but less than 24 hours) **CIV**- continuous intravenous infusion (greater than 24 hours) **IA**- intra-arterial **IT**- intrathecal **IP**- intraperitoneal **IH**- intrahepatic **IHI**- intrahepatic infusion **SC**- subcutaneous **T**- topical **PO**- oral **RT**- radiation or other route as specified in the protocol.	Use pick list.
Lot #	Enter the Lot Number for the medication supply.	24 characters
Vial #	Enter the Vial Number for the medication	50 characters
Duration	Duration from the start date/time and stop date/time.	6 digits & 2 decimals
Duration UOM (m) ...	Select a unit of measurement so that the duration can be derived. **DY**- Days **HR**- Hours **MN**- Minutes **MO**- Months **Wk**- Weeks	Use pick list.
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

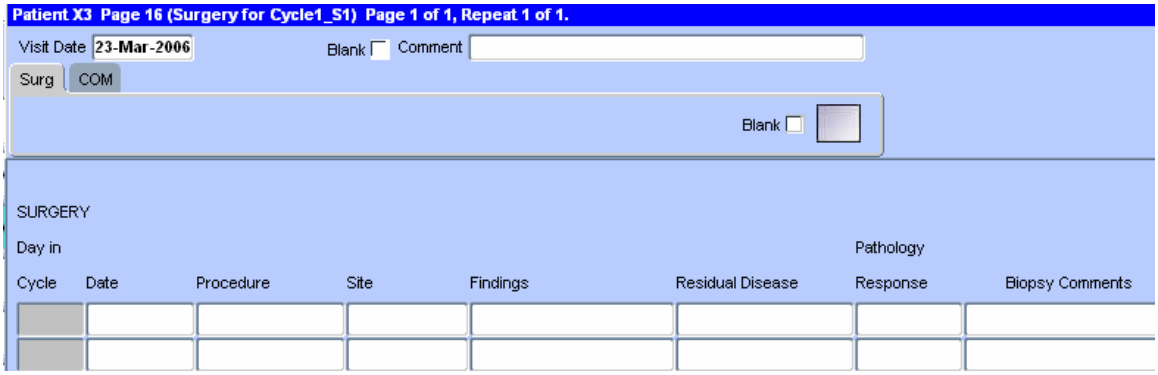
(STUDY DRUG ADMINISTRATION)

Surgery

Purpose

Record details of surgery performed as part of the treatment when required by the protocol.

Surgery eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Date of Vitals field.	DD-MMM-YYYY
Date of Surgery (m)	Enter the date of the surgical procedure.	DD-MMM-YYYY
Procedure (m)	Enter the type of procedure performed to diagnose / to treat the patient's disease. Examples include, but not limited too: biopsy, node dissection, cytology, bone marrow biopsy, FNA (fine needle aspiration).	24 characters
Site (m) ...	Select the anatomical site of the procedure.	Use pick list.
Findings	Briefly describe the findings of the procedure.	24 characters

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Residual Disease	Briefly describe the extent of the residual disease, if any, at the conclusion of the operation. (i.e.: microscopic, macroscopic).	24 characters
Pathology Response ▪▪▪	CR – Complete Response PR – Partial Response NR – No Response	Use pick list.
Biopsy Comments	General comments	200 characters
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(SURGERY)

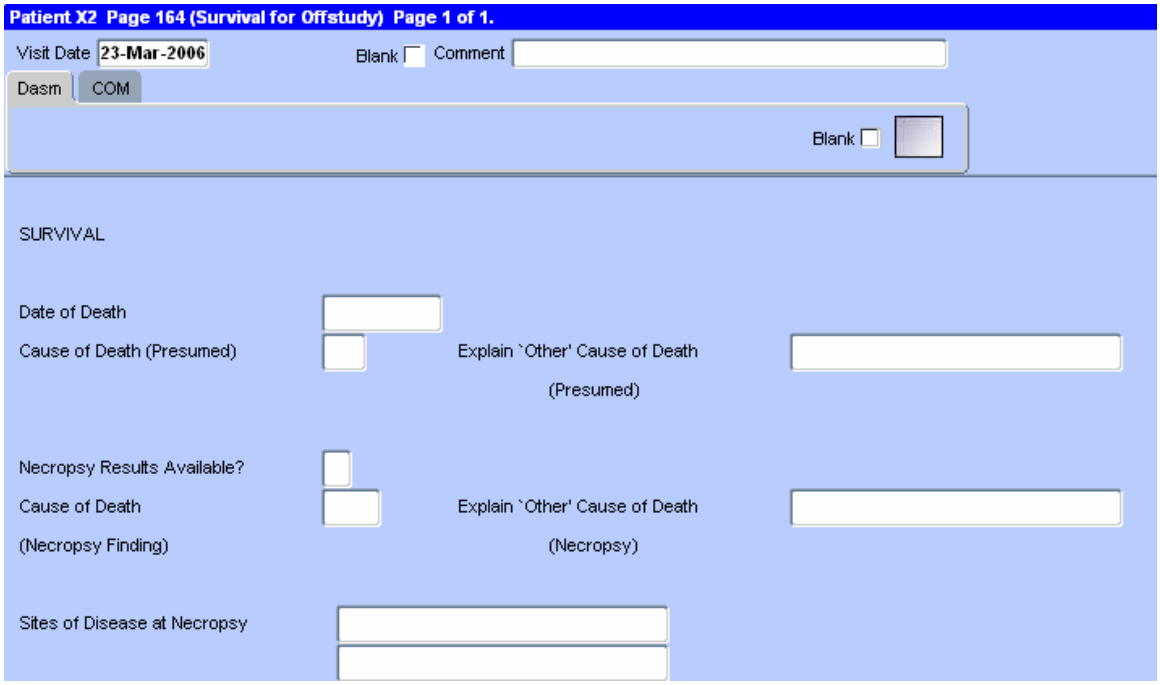
Survival

Purpose

Use this form to record information about the patient's death and necropsy results if applicable.

Note: Only the Date of Death is sent to CTMS if there is an indication, on the Follow-up case report form, that the patient has received further treatment. All the fields still need to be entered though.

Survival eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Date of Last Contact field.	DD-MMM-YYYY
Date of Death (m)	Enter the date the patient has died.	DD-MMM-YYYY
Cause of Death (Presumed) (m) ...	If the patient died without intervening therapy specific to the disease for which the patient was put on study, this section should be completed. Categorize the cause as due to: M- Malignant Disease T- Toxicity from Protocol Treatment I- Infection O- Other (Explain) If "Other" is checked, enter a succinct description of the presumed cause of death on the field "Explain 'Other' Presumed Cause of Death".	Use pick list.
Explain 'Other' Cause of Death (Presumed)	Enter a succinct description if option "Other" is selected as presumed cause of death. For example: Concurrent illness/renal failure".	24 characters
Necropsy Results Available? ... (m)	Select an option indicating whether the results of an necropsy are available. Y- **Yes** - Necropsy done and results available. N- **No** - Necropsy not done or necropsy done, but results not yet available. U- **Unknown** - Do not know if a necropsy was done. If the necropsy results are still pending, select "No" and update this CRF when the results are available.	Use pick list.

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Cause of Death (Necropsy Finding) ...	If an necropsy was performed and a cause of death was determined at necropsy, it should be categorized according to: M- Malignant Disease T- Toxicity from Protocol Treatment I- Infection O- Other Only one category should be checked. If "Other" is checked, enter a succinct description of the necropsy finding cause of death on the field "Explain 'Other' Necropsy Finding Cause of Death".	Use pick list.
Explain 'Other' Cause of Death (Necropsy Finding)	If option "Other" is selected as necropsy finding cause of death, enter a succinct description, i.e., MI.	24 characters
Sites of Disease (Necropsy Finding) ...	Select the major sites of malignant disease involvement found at the necropsy, i.e., heart, brain, lungs, etc.	Use pick list.
Legend: ... pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

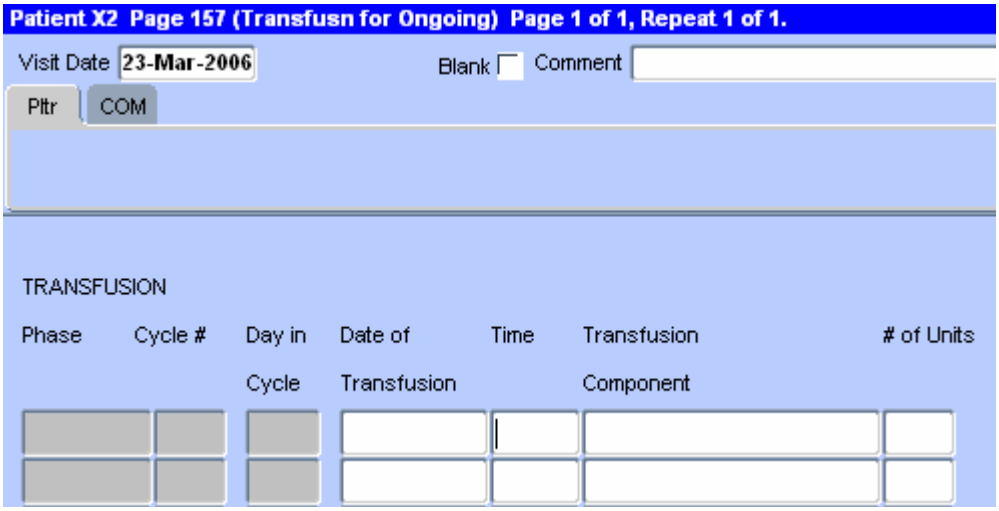
(SURVIVAL)

Transfusions

Purpose

Record the patient's received transfusions.

Transfusions eCRF



Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Visit Date	The Visit Date is optional on this case report form. Hit the "Tab" key to leave it empty and move to the Date field.	DD-MMM-YYYY
Phase [(d)]	Derived as ‘Study 1’ or ‘Study 2’	10 Characters
Cycle # [(d)]	Indicates the cycle number the transfusion is related to based on their date and the Cycle Initiation start dates.	5 digits
Day in Cycle [(d)]	Indicates the day since the beginning of cycle the transfusion is related to based on their date and the Cycle Initiation start dates.	5 digits
Date [(m)]	Enter the date that the transfusion was done.	DD-MMM-YYYY
Time	Enter the time the transfusion was done.	HH(24):MM

Field Descriptions and Instructions		
Field Name	**Description / Instructions**	**Format**
Transfusion Component (m) ▪▪▪	Select the transfusion component from the pick list.	Use pick list.
# of Units (m)	Enter the blood component number of units transfused (in Units)	3 digits
Legend: ▪▪▪ pick list available, (d) derived field, (m) RDC mandatory, (c) for CTEP reporting only.		

(TRANSFUSIONS)

Appendices

Appendix I - Useful References

NIH	
National Institutes of Health	http://www.nih.gov/
National Cancer Institute	http://www.cancer.gov/
Glossary of Clinical Trials Terms	http://clinicaltrials.gov/ct/gui/info/glossary
CCR/COP	
COP Comparative Oncology Program	http://ccr.cancer.gov/resources/cop/
C3D RDC Login - Intranet	http://ccrtrials.nci.nih.gov/CCR_trials/C3DS/C3D_Users_Login
C3D RDC Login – External Sites	https://octrials.nci.nih.gov/opa45/rdclaunch.htm
C3D RDC Test Mode Login – External Sites	https://octrials.nci.nih.gov/opa45/rdclauncht.htm
C3D Support	http://ncicbsupport.nci.nih.gov/sw/content/C3D.html