# NROR Data Dictionary
## Version 3.0

*Released September 3, 2013*

**MISSION:**

The overarching mission of the National Radiation Oncology Registry (NROR) is to improve the care of cancer patients by collecting reliable real-world information on radiation treatment delivery and health outcomes.

**PURPOSE:**

The purpose of the NROR is to enable comparative care for cancer patients with similar profiles and disease states, eventually link comparative care with best outcomes and quality improvement and create a population-based health services registry.

**DISEASE SITE:**

Pilot in Prostate Cancer

**DATA DICTIONARY:**

The NROR Prostate Cancer Data Dictionary is a collection of carefully defined data elements designed to characterize critical aspects of the treatment of patients with intact prostate cancer with various forms of radiotherapy. The Data Dictionary was developed with guidance from prostate cancer and technical experts, health services researchers, and medical informaticists to provide standardized data elements in 7 major domains: facility characteristics, physician demographics, patient demographics, prostate cancer disease characteristics, medical history and comorbidities, technical radiotherapy and dosimetric data, and clinician-reported outcomes.

**ACKNOWLEDGEMENTS:**

The NROR Prostate Cancer Data Dictionary is comprised of data elements derived from authoritative sources in radiation oncology, including the Radiation Therapy Oncology Group (RTOG) radiotherapy trials, the CaPSURE (Cancer of the Prostate Strategic Urologic Research Endeavor) database, the QUANTEC (Quantitative Analysis of Normal Tissue Effects in the Clinic) review of radiotherapy toxicity, the Quality Research in Radiation Oncology (QRRO) patterns of care studies, the National Cancer Institute (NCI) Common Toxicity Criteria, AHRQ processes of care elements, the American College of Radiology facility descriptors, SEER (Surveillance, Epidemiology and End Results) Program, the North American Association of Central Cancer Registries (NAACR), and the NCI Thesaurus.

**NROR**
NATIONAL RADIATION ONCOLOGY REGISTRY

AN INITIATIVE OF THE ROI IN PARTNERSHIP WITH ASTRO

**NROR Data Dictionary Version 3.0**

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# Version Control

Version 3 Updates Effective Date: September 3, 2013

### General Revisions
- Formatting was modified to move GatewayName to the bottom for each element and rearrange the location of the data element ID#'s.
- Required questions were allocated by "This field is required" added to the instructions.

### Facility Registration Form
- Combined facility address questions into one data element. The facility street address, city, state, zip code questions were combined into one question, "what is the mailing address of the facility" – ID# 1002.
- Numbering of the questions changed as questions 1002-1005 were combined and became question 1002 as indicated above.
- Required fields indicated – ID# 1001, 1002, 1003, 1005, 1006, 1008, 1009, 1011, 1012, 1013, 1015, 1016, 1018, 1019, 1021, 1022, 1023, 1024, 1025, 1026, 1027, and 1028.

### Physician Registration Form
- Required fields indicated – ID# 2001, 2002, 2004, 2005, 2006, 2007, 2008, and 2009.

### Patient Demographics Form
- Question text was modified for ID# 3006: "what was the patient's gender" was changed to "what is the patient's sex". Instructions for this question were updated to "indicate the biological makeup of the patient's reproductive anatomy at birth". The GatewayName was changed to "Sex."
- Required fields indicated – ID# 3001, 3002, 3004, 3005, 3006, 3007, and 3008.

### Prostate Cancer Diagnosis Form
- Required fields indicated – ID# 4001, 4004, 4005, 4006, 4007, 4008, 4009, 4010, 4011, 4012, 4014, and 4015.
- Changed question text for ID# 4005 and 4006 to read "abdomen and**/or** pelvis"
- Changed the coding options for ID# 4013: "what is the tertiary Gleason grade." Coding options now include Gleason Grade 1, Gleason Grade 2, Gleason Grade 3, Gleason Grade 4, Gleason Grade 5, and Unknown.
- Modified question text for ID# 4014. Changed question to read "Is the baseline (prior to the initiation of treatment) Prostate Specific Antigen (PSA) value known". The GatewayName was changed to "BaselinePSAValueKnown"
- Modified question text for ID# 4015. Changed question to read "what was the baseline PSA value prior to the initiation treatment" The GatewayName was changed to "BaselinePSAValue".
- Modified question text for ID# 4016. Changed question to read "what were the units of the baseline PSA value prior to the initiation of treatment". The GatewayName was changed to "BaselinePSAUnits"
- Modified question text for ID# 4017. Changed question to read "what was the date of the baseline PSA value prior to the initiation of treatment". The GatewayName was changed to "BaselinePSADate"

### Treatment Course Form

- Deleted ID# 5017-5019 and renumbered remaining questions. Questions "was image guided radiation therapy (IGRT) used in conjunction with this treatment course"; "please select all image guided radiation therapy (IGRT) types used in this treatment course" and "specify the "Other" IGRT type used in this treatment course" were deleted.
- Coding options were modified for ID# 5009. Coding options now include: "< 6 months; 6-11 months; 12-24 months; >24 months; Unknown; Indefinite"
- Format for ID# 5017 changed from radio button to checkboxes to allow multiple selections.
- Required fields indicated – ID# 5002, 5003, 5004, 5008, 5009, 5010, 5011, 5012, 5013, 5014, 5015, and 5017.

### EBRT Prescription Form

- Additional instructions were added for ID# 6006 – "If more than one prescription/plan is used in this treatment course (e.g. a boost to the prostate), complete an additional EBRT form. Please note that "Prostate Gland, Seminal Vesicles, and Pelvic Nodes" should be selected for any treatment to the whole pelvis."
- Coding options were modified for ID# 6013 to include "fiducial markers with cone beam CT" as code 5. Coding numbers were modified to accommodate this addition.
- Required fields indicated – ID# 6001, 6004, 6005, 6006, 6007, 6008, 6009, 6013, and 6015.

### Brachytherapy Prescription Form

- Required fields indicated – ID# 7010, 7011, and 7012.

### Patient Cause of Death Form (previously "Patient Vital Status")

- Renamed the "Patient Vital Status" form to "Patient Cause of Death" form. This form will only appear if code 0 (deceased) for ID# 9004, question "what is the patient's status" is selected.
- Moved ID# 8001-8004 from this form to the Prostate Cancer Follow-up form. Renumbered questions on this form accordingly.
- Required fields indicated – ID# 8001 and 8002.

### Prostate Cancer Follow-up Form

- Modified question text for ID# 9016-9018. Changed the wording in text from "salvage" to "secondary".
- Added an additional coding option to ID# 9017. Coding option "additional hormonal therapy" was added to the list of permissible values.
- Required fields indicated – ID# 9001, 9002, 9003, 9004, 9022, 9023, 9024, 9025, 9026, and 9027.

### Charlson Comorbidity Index (CCI) Form

- No changes

### DVH Summary Statistics Form

- Modified question text for ID# 11006-11013. New wording for each question is:
  - ID# 11006-What volume of the bladder received 70 Gy in cc?
  - ID# 11007-What percentage of the bladder received 70 Gy?
  - ID# 11008-What volume of the bladder received 40 Gy in cc?
  - ID# 11009-What percentage of the bladder received 40 Gy?
  - ID# 11010-What volume of the rectum received 70 Gy in cc?
  - ID# 11011-What percentage of the rectum received 70 Gy?
  - ID# 11012-What volume of the rectum received 40 Gy in cc?
  - ID# 11013-What percentage of the rectum received 40 Gy?

| | |
|---|---|
| **Data Entry Form:** | **Facility Registration** |
| Module | NROR Facility Module |
| Parent Entity: | Facility |
| Submission Frequency: | Once, updated annually |
| Revision Date: | August 23, 2013 |

| | |
|---|---|
| **ID #:** | **1001** |
| **Question Text:** | **What is the name of the facility?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Text / Long |
| **GatewayName:** | Facilityname |
| **ID #:** | **1002** |
| **Question Text:** | **What is the mailing address of the facility?** |
| **Instructions:** | **This field is required.** Facility street address (include building and/or suite, if applicable), City, State, and Zip code. |
| **Type / Length / Format:** | Text |
| **Permissible Values:** | n/a |
| **GatewayName:** | FacilityMailingAddress |
| **ID #:** | **1003** |
| **Question Text:** | **What is the facility's main phone number?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Text / Short / ###-###-#### |
| **Permissible Values:** | n/a |
| **GatewayName:** | FacilityPhoneNumber |
| **ID #:** | **1004** |
| **Question Text:** | **What is the facility's main fax number?** |
| **Instructions:** | |
| **Type / Length / Format:** | Text / Short / ###-###-#### |
| **Permissible Values:** | n/a |
| **GatewayName:** | FacilityFax |
| **ID #:** | **1005** |
| **Question Text:** | **Please provide information for the primary contact at this facility.** |
| **Instructions:** | **This field is required.** Provide name, phone number, and email. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | PrimaryContact |

| | |
|---|---|
| **ID #:** | **1006** |
| **Question Text:** | **Which of the following best describes your facility type?** |
| **Instructions:** | **This field is required.**<br>Choose one. |
| **Type / Length / Format:** | Radio – Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | Community Hospital |
| 2 | Freestanding Facility |
| 3 | Academic Hospital |
| 4 | NCI-designated Comprehensive Cancer Center |
| 5 | Veterans Administration Hospital |
| 888 | Other (specify) |

| | |
|---|---|
| **GatewayName:** | FacilityType |
| **ID #:** | **1007** |
| **Question Text:** | **Specify the "Other" type that best describes your facility.** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherFacilityType |
| **ID #:** | **1008** |
| **Question Text:** | **Is the treatment record completely electronic and no longer recorded in hardcopy?** |
| **Instructions:** | **This field is required.**<br>Choose one. |
| **Type / Length / Format:** | Radio – Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | ElectronicTreatmentRecord |

|  |  |
|---|---|
| **ID #:** | **1009** |
| **Question Text:** | **Select all electronic health record systems in use by the Radiation Oncology Department at this facility.** |
| **Instructions:** | **This field is required.**<br>Check all that apply. |
| **Type / Length / Format:** | Checkbox - Multiple |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | ARIA |
| 2 | MOSAIQ |
| 3 | ONCOCHART |
| 4 | Medi Tech |
| 5 | McKesson |
| 6 | Epic |
| 7 | GE Star |
| 8 | NextGen |
| 888 | Other (Specify) |

|  |  |
|---|---|
| **GatewayName:** | EHRSystems |
| **ID #:** | **1010** |
| **Question Text:** | **Specify the "Other" electronic health record system in use at this facility.** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherEHR |
| **ID #:** | **1011** |
| **Question Text:** | **Are simulation images electronic at this facility?** |
| **Instructions:** | **This field is required.**<br>Choose one. |
| **Type / Length / Format:** | Radio – Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

|  |  |
|---|---|
| **GatewayName:** | ElectronicSimImages |

| | |
|---|---|
| **ID #:** | **1012** |
| **Question Text:** | **Are port films electronic at this facility?** |
| **Instructions:** | **This field is required.**<br>Choose one. |
| **Type / Length / Format:** | Radio – Single |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | ElectronicPortFilms |

| | |
|---|---|
| **ID #:** | **1013** |
| **Question Text:** | **Please select all treatment planning systems in use at this facility.** |
| **Instructions:** | **This field is required.**<br>Check all that apply. |
| **Type / Length / Format:** | Checkbox – Multiple |

| Code | Description |
|---|---|
| 1 | BrainLab iPlan |
| 2 | Varian Eclipse |
| 3 | Nucletron Oncentra |
| 4 | Philips Pinnacle |
| 5 | Elekta Xio |
| 888 | Other (Specify) |

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|---|---|
| **GatewayName:** | TreatmentPlanningSystemsType |

| | |
|---|---|
| **ID #:** | **1014** |
| **Question Text:** | **Specify the "Other" treatment planning system in use at this facility** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherTPS |

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|---|---|
| **ID #:** | **1015** |
| **Question Text:** | **Are image guided radiation therapy (IGRT) services offered at this facility?** |
| **Instructions:** | **This field is required.**<br>Choose one. |
| **Type / Length / Format:** | Radio – Single |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | IGRTOffered |

| | |
|---|---|
| **ID #:** | **1016** |
| **Question Text:** | **Please select all image guided radiation therapy (IGRT) services offered at this facility.** |
| **Instructions:** | **This field is required.** |
| | Appears only if "Yes" is selected for previous question. |
| | Check all that apply. |
| **Type / Length / Format:** | Checkbox – Multiple |

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | MV planar imaging |
| 2 | kV planar imaging |
| 3 | MV Cone Beam CT or CT |
| 4 | kV Cone Beam CT |
| 5 | CT on rails |
| 6 | Radio Beacon |
| 7 | Ultrasound |
| 8 | MRI |
| 888 | Other (Specify) |

**GatewayName:** IGRTTypeUsed

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|---|---|
| **ID #:** | **1017** |
| **Question Text:** | **Specify the "Other" IGRT in use at this facility** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherIGRT |

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|---|---|
| **ID #:** | **1018** |
| **Question Text:** | **Are immobilization services offered at this facility?** |
| **Instructions:** | **This field is required.** |
| | Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** ImmobilizationOffered

| | |
|---|---|
| **ID #:** | **1019** |
| **Question Text:** | **Please select all immobilization techniques in use at this facility.** |
| **Instructions:** | **This field is required.** |
| | Appears only if "Yes" is selected for previous question. Check all that apply. |
| **Type / Length / Format:** | Checkbox – Multiple |
| **Permissible Values:** | (see table below) |

| Code | Description |
|---|---|
| 1 | Body Mould |
| 2 | Rectal Balloon |
| 3 | Leg Fixation |
| 888 | Other (specify) |

| | |
|---|---|
| **GatewayName:** | ImmobilizationTechniques |
| **ID #:** | **1020** |
| **Question Text:** | **Specify the "Other" immobilization technique in use at this facility.** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherImmobilization |
| **ID #:** | **1021** |
| **Question Text:** | **Please specify the number of MV external beam photon treatment machines in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberOfEBRTMachines |
| **ID #:** | **1022** |
| **Question Text:** | **Please specify the number of single energy linear accelerators in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberOfSingleEnergyLinacs |
| **ID #:** | **1023** |
| **Question Text:** | **Please specify the number of multiple energy linear accelerators in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberofMultipleEnergyLinacs |

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|---|---|
| **ID #:** | **1024** |
| **Question Text:** | **Please specify the number of o-ring treatment machines (e.g. Tomotherapy, ViewRay) in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberofORingTreatmentMachines |
| **ID #:** | **1025** |
| **Question Text:** | **Please specify the number of robotic linear accelerators (e.g. Cyberknife) in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberofRoboticLinacs |
| **ID #:** | **1026** |
| **Question Text:** | **Please specify the number of proton beam lines in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberofProtonBeamLines |
| **ID #:** | **1027** |
| **Question Text:** | **Please specify the number of other treatment machines (not specified above) in use at this facility.** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | NumberofOtherTreatmentMachines |

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|---|---|
| **ID #:** | **1028** |
| **Question Text:** | **How often are chart checks done by the physicists or certified dosimetrists at this facility?** |
| **Instructions:** | **This field is required.** |
| | Choose one. |
| **Type / Length / Format:** | Radio – single answer |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | More than weekly |
| 1 | Weekly |
| 2 | Biweekly |
| 3 | Monthly |
| 4 | Never |

**GatewayName:** ChartChecks

| | |
|---|---|
| **Data Entry Form:** | **Physician Registration** |
| Module Name: | NROR Physician Module |
| Parent Entity: | Physician |
| Submission Frequency: | Once, updated annually |
| Revision Date: | August 23, 2013 |

| | |
|---|---|
| **ID #:** | **2001** |
| **Question Text:** | **What is the physician's last name?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Text / Long |
| **Permissible Values:** | n/a |
| **GatewayName:** | PhysicianLastName |

| | |
|---|---|
| **ID #:** | **2002** |
| **Question Text:** | **What is the physician's first name?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Text / Long |
| **Permissible Values:** | n/a |
| **GatewayName:** | PhysicianFirstName |

| | |
|---|---|
| **ID #:** | **2003** |
| **Question Text:** | **What is the physician's middle name?** |
| **Instructions:** | It is acceptable to specify the middle initial. |
| **Type / Length / Format:** | Text / Long |
| **Permissible Values:** | n/a |
| **GatewayName:** | PhysicianMiddleName |

| | |
|---|---|
| **ID #:** | **2004** |
| **Question Text:** | **What is the physician's national provider identifier (NPI)?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Number (10 digits) |
| **Permissible Values:** | n/a |
| **GatewayName:** | NPI |

| | |
|---|---|
| **ID #:** | **2005** |
| **Question Text:** | **What is the physician's primary specialty?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Dropdown |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | Allergy & Immunology |
| 2 | Anesthesia |
| 3 | Cardiology |

| | |
|---|---|
| 4 | Dermatology |
| 5 | Emergency Medicine |
| 6 | Endocrinology and Metabolism |
| 7 | Family Practice |
| 8 | Gastroenterology |
| 9 | General Practice |
| 10 | Geriatric Medicine |
| 11 | Gynecology |
| 12 | Gynecologic Oncology |
| 13 | Hematology |
| 14 | Infectious Diseases |
| 15 | Internal Medicine |
| 16 | Neonatology |
| 17 | Nephrology |
| 18 | Neurology |
| 19 | Neurological Surgery |
| 20 | Obstetrics and Gynecology |
| 21 | Oncology, Medical |
| 22 | Ophthalmology |
| 23 | Orthopedic Surgery |
| 24 | Otorhinolaryngology |
| 25 | Pathology |
| 26 | Pediatrics |
| 27 | Physical Medicine and Rehab |
| 28 | Plastic Surgery |
| 29 | Podiatry |
| 30 | Preventive Medicine |
| 31 | Psychiatry |
| 32 | Pulmonary Disease |
| 33 | Radiology, Diagnostic |
| 34 | Radiology, Nuclear |
| 35 | Radiation Oncology |
| 36 | Rheumatology |
| 37 | Sports Medicine |
| 38 | Surgery, General |
| 39 | Surgery, Hand |
| 40 | Surgery, Thoracic |
| 41 | Surgery, Vascular |
| 42 | Surgery, Colon and Rectal |
| 43 | Surgery, Urology |
| 888 | Other |

**GatewayName:** PrimarySpecialty

| | |
|---|---|
| **ID #:** | **2006** |
| **Question Text:** | **In what year did this physician complete residency training?** |
| **Instructions:** | **This field is required.** Enter the year in YYYY format. |
| **Type / Length / Format:** | Date / 'YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | ResidencyCompletionYear |

| | |
|---|---|
| **ID #:** | **2007** |
| **Question Text:** | **Is this physician board certified in his or her primary specialty?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio – Single |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 2 | Pending |

| | |
|---|---|
| **GatewayName:** | BoardCertification |

| | |
|---|---|
| **ID #:** | **2008** |
| **Question Text:** | **In what year was this physician board certified?** |
| **Instructions:** | **This field is required.** Enter the year in YYYY format. Appears only if BoardCertification = "Yes." |
| **Type / Length / Format:** | Date / 'YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | BoardCertificationYear |

| | |
|---|---|
| **ID #:** | **2009** |
| **Question Text:** | **Is this physician currently participating in Maintenance of Certification (MOC)?** |
| **Instructions:** | **This field is required.** Choose one. Appears only if BoardCertification = "Yes". |
| **Type / Length / Format:** | Radio – Single |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 777 | Not Applicable |

| | |
|---|---|
| **GatewayName:** | MOC |

| | |
|---|---|
| **Form Name:** | **Patient Demographics** |
| Module Name | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once at the time of initial patient submission |
| Revision Date: | August 23, 2013 |

**ID #: 3001**

**Question Text:** **What is the patient's last name?**

**Instructions:** **This field is required.**

**Type / Length / Format:** Text / Long

**Permissible Values:** n/a

**GatewayName:** PatientLastName

**ID #: 3002**

**Question Text:** **What is the patient's first name?**

**Instructions:** **This field is required.**

**Type / Length / Format:** Text / Long

**Permissible Values:** n/a

**GatewayName:** PatientFirstName

**ID #: 3003**

**Question Text:** **What is the patient's middle name?**

**Instructions:** It is acceptable to specify the middle initial.

**Type / Length / Format:** Text / Long

**Permissible Values:** n/a

**GatewayName:** PatientMiddleName

**ID #: 3004**

**Question Text:** **What is the patient's date of birth in the format MM/DD/YYYY?**

**Instructions:** **This field is required.**
Enter the date in the format MM/DD/YYYY.

**Type / Length / Format:** Date / 'MM/DD/YYYY'

**Permissible Values:** n/a

**GatewayName:** BirthDate

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**ID #:** **3005**

**Question Text:** **What is the patient's medical record number (MRN)?**

**Instructions:** <span style="color:red">**This field is required.**</span>
Sites may enter a unique patient identifier that is not the medical record number if MRN is not available.

**Type / Length / Format:** Text / Medium

**Permissible Values:** n/a

**GatewayName:** MRN

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**ID #:** **3006**

**Question Text:** **What is the patient's sex?**

**Instructions:** <span style="color:red">**This field is required.**</span>
Please indicate the biological makeup of the patient's reproductive anatomy at birth.

**Type / Length / Format:** Radio – Single
*Values are coded using NCI Thesaurus concept codes.

**Permissible Values:**

| Code | Description |
|------|-------------|
| C20197 | Male |
| C16576 | Female |
| C17998 | Decline / Unknown |

**GatewayName:** Sex

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**ID #:** **3007**

**Question Text:** **What is the patient's ethnicity?**

**Instructions:** <span style="color:red">**This field is required.**</span>
Choose one.

**Type / Length / Format:** Radio – Single
*Values are coded using NCI Thesaurus concept codes and aligned with:
AHRQ report to the Institute of Medicine on Race, Ethnicity, and Language Data Standardization for Health Care Quality Improvement:
http://www.ahrq.gov/research/iomracereport/reldata3.htm
Office of Management and Budget. 1997 Revisions to the standards for the classification of federal data on race and ethnicity. *Federal Register* 62:58781-58790.

**Permissible Values:**

| Code | Description |
|------|-------------|
| C17459 | Hispanic or Latino |
| C41222 | Not Hispanic or Latino |
| C17998 | Decline / Unknown |

**GatewayName:** Ethnicity

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|---:|:---|
| **ID #:** | **3008** |
| **Question Text:** | **What is the patient's race?** |
| **Instructions:** | **This field is required.** |
| | Check all that apply. |
| **Type / Length / Format:** | Checkbox - multiple |
| | *Values are coded using NCI Thesaurus concept codes and aligned with: AHRQ report to the Institute of Medicine on Race, Ethnicity, and Language Data Standardization for Health Care Quality Improvement: http://www.ahrq.gov/research/iomracereport/reldata3.htm Office of Management and Budget. 1997 Revisions to the standards for the classification of federal data on race and ethnicity. *Federal Register* 62:58781-58790. |

**Permissible Values:**

| Code | Description |
|---|---|
| C41259 | American Indian or Alaska Native |
| C41260 | Asian |
| C16352 | Black or African American |
| C41219 | Native Hawaiian or Other Pacific Islander |
| C41261 | White |
| C17998 | Decline / Unknown |

**GatewayName:** Race

| | |
|---|---|
| **Data Entry Form:** | **Prostate Cancer Diagnosis** |
| Module Name | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once at the time of initial patient submission for this disease. |
| Revision Date: | August 23, 2013 |

| | |
|---|---|
| **ID #:** | **4001** |
| **Question Text:** | **What is the ICD-10-CM diagnosis code for this prostate cancer?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Radio - Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| C61 | Malignant neoplasm of prostate |

| | |
|---|---|
| **GatewayName:** | ICD10CMDiagnosisCode |
| **ID #:** | **4002** |
| **Question Text:** | **What was the date of the initial diagnostic biopsy?** |
| **Instructions:** | Enter the date in the format MM/DD/YYYY. |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | DiagnosticBiopsyDate |
| **ID #:** | **4003** |
| **Question Text:** | **What was the date of the initial consultation with the radiation oncologist?** |
| **Instructions:** | Enter the date in the format MM/DD/YYYY. |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | InitialConsultDate |

| | |
|---|---|
| **ID #:** | **4004** |
| **Question Text:** | **Indicate the histopathologic type.** |
| **Instructions:** | **This field is required.** |
| | Choose one. |
| **Type / Length / Format:** | Dropdown – Single |
| | *Values are coded using NCI Thesaurus concept codes. Equivalent/associated ICD-O-3 histology codes are also indicated. |

**Permissible Values:**

| Code NCI | Description (ICD-O-3) |
|---|---|
| C2919 | Prostate Adenocarcinoma (8140/3) |
| C5596 | Acinar Prostate Adenocarcinoma (8550/3) |
| C39880 | Acinar Prostate Adenocarcinoma, Atrophic Variant |
| C39882 | Acinar Prostate Adenocarcinoma, Foamy Gland Variant |
| C39885 | Acinar Prostate Adenocarcinoma, Lymphoepithelioma-Like Variant |
| C39884 | Acinar Prostate Adenocarcinoma, Oncocytic Variant |
| C39881 | Acinar Prostate Adenocarcinoma, Pseudohyperplastic Variant |
| C5530 | Acinar Prostate Adenocarcinoma, Sarcomatoid Variant |
| C5535 | Acinar Prostate Adenocarcinoma, Signet Ring Variant |
| C5537 | Acinar Prostate Mucinous Adenocarcinoma |
| C6813 | Prostate Ductal Adenocarcinoma (8500/3) |
| C39895 | Prostate Ductal Adenocarcinoma, Cribriform Pattern |
| C39896 | Prostate Ductal Adenocarcinoma, Papillary Pattern |
| C39897 | Prostate Ductal Adenocarcinoma, Solid Pattern |
| C5539 | Prostate Adenoid Cystic Carcinoma (8200/3) |
| C5538 | Prostate Adenosquamous Carcinoma (8560/3) |
| C39902 | Prostate Basal Cell Carcinoma (8147/3) |
| C6766 | Prostate Small Cell Carcinoma (8041/3) |
| C5536 | Prostate Squamous Cell Carcinoma (8070/3) |
| C5597 | Undifferentiated Prostate Carcinoma (8020/3) |
| C39898 | Primary Prostate Urothelial Carcinoma (8120/3) |
| C5533 | Prostate Lymphoma (9590/3) |
| C5527 | Prostate Myeloid Sarcoma (9930/3) |
| C7731 | Prostate Sarcoma (8800/3) |

**GatewayName:** ProstateCancerHistopathologicType

| | |
|---|---|
| **ID #:** | **4005** |
| **Question Text:** | **Was a CT scan of the abdomen and/or pelvis obtained for staging purposes?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes – ordered by radiation oncologist |
| 2 | Yes – ordered by a referring provider |
| 999 | Unknown |

**GatewayName:** StagingCTObtained

| | |
|---|---|
| **ID #:** | **4006** |
| **Question Text:** | **Was an MRI of the abdomen and/or pelvis obtained for staging purposes?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes – ordered by radiation oncologist |
| 2 | Yes – ordered by a referring provider |
| 999 | Unknown |

**GatewayName:** StagingMRIObtained

| | |
|---|---|
| **ID #:** | **4007** |
| **Question Text:** | **Was a bone scan obtained for staging purposes?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes – ordered by radiation oncologist |
| 2 | Yes – ordered by a referring provider |
| 999 | Unknown |

**GatewayName:** StagingBoneScanObtained

| | |
|---|---|
| **ID #:** | **4008** |
| **Question Text:** | **What was the clinical primary tumor classification at the time of diagnosis, according to AJCC v7 criteria?** |
| **Instructions:** | **This field is required.** <br> Choose one. |
| **Type / Length / Format:** | Radio – Single <br> *Values are coded using NCI Thesaurus concept codes. |

**Permissible Values:**

| Code | Description |
|---|---|
| C89208 | cTX - Primary tumor cannot be assessed. |
| C89209 | cT0 - No evidence of primary tumor. |
| C89210 | cT1 - Clinically inapparent tumor neither palpable nor visible by imaging. |
| C89211 | cT1a - Tumor incidental histologic finding in 5% or less of tissue resected. |
| C89212 | cT1b - Tumor incidental histologic finding in more than 5% of tissue resected. |
| C89213 | cT1c - Tumor identified by needle biopsy (e.g., because of elevated PSA). |
| C89214 | cT2 - Prostate cancer confined within the prostate. Tumor found in one or both lobes by needle biopsy, but not palpable or reliably visible by imaging, is classified as T1c. |
| C89215 | cT2a - Prostate cancer with tumor involving one-half of one lobe or less. |
| C89216 | cT2b - Prostate cancer with tumor involving more than one-half of one lobe, but not both lobes. |
| C89217 | cT2c - Prostate cancer with tumor involving both lobes. |
| C89218 | cT3 - Prostate cancer extending through the prostatic capsule. Invasion into the prostatic apex or into (but not beyond) the prostatic capsule is classified not as T3 but as T2. |
| C89219 | cT3a - Prostate cancer with extracapsular extension (unilateral or bilateral). |
| C89220 | cT3b - Prostate cancer invading seminal vesicle(s). |
| C89221 | cT4 - Prostate cancer with fixed tumor or tumor invading adjacent structures other than seminal vesicles such as external sphincter, rectum, bladder, levator muscles, and/or pelvic wall. |

**GatewayName:** ClinicalPrimaryTumorClassification

| | |
|---|---|
| **ID #:** | **4009** |
| **Question Text:** | **What was the clinical regional lymph node classification at the time of diagnosis, according to AJCC v7 criteria?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single *Values are coded using NCI Thesaurus concept codes. |

**Permissible Values:**

| Code | Description |
|---|---|
| C89223 | cNX - Prostate cancer in which the regional lymph nodes cannot be assessed. |
| C89224 | cN0 - Prostate cancer with no regional lymph node metastasis. |
| C89225 | cN1 - Prostate cancer with metastasis in regional lymph node(s). |

**GatewayName:** ClinicalRegionalLymphNodeClassification

| | |
|---|---|
| **ID #:** | **4010** |
| **Question Text:** | **What was the clinical distant metastasis classification at the time of diagnosis, according to AJCC v7 criteria?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single *Values are coded using NCI Thesaurus concept codes. |

**Permissible Values:**

| Code | Description |
|---|---|
| C89227 | cM0 - Prostate cancer without evidence of distant metastasis. |
| C89228 | cM1 - Prostate cancer with distant metastasis. |
| C89229 | cM1a - Prostate cancer with metastasis to non-regional lymph node(s). |
| C89230 | cM1b - Prostate cancer with metastasis to bone(s). |
| C89231 | cM1c - Prostate cancer with metastasis to other site(s) with or without bone disease. |

**GatewayName:** ClinicalDistantMetastasisClassification

| | |
|---|---|
| **ID #:** | **4011** |
| **Question Text:** | **What is the primary Gleason grade?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | Gleason Grade 1 |
| 2 | Gleason Grade 2 |
| 3 | Gleason Grade 3 |
| 4 | Gleason Grade 4 |
| 5 | Gleason Grade 5 |
| 999 | Unknown |

**GatewayName:** PrimaryGleasonGrade

| ID #: | **4012** |
|---|---|
| **Question Text:** | **What is the secondary Gleason grade?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single |

| Code | Description |
|---|---|
| 1 | Gleason Grade 1 |
| 2 | Gleason Grade 2 |
| 3 | Gleason Grade 3 |
| 4 | Gleason Grade 4 |
| 5 | Gleason Grade 5 |
| 999 | Unknown |

**GatewayName:** SecondaryGleasonGrade

| ID #: | **4013** |
|---|---|
| **Question Text:** | **What is the tertiary Gleason grade?** |
| **Instructions:** | Choose one. |
| **Type / Length / Format:** | Radio - Single |

| Code | Description |
|---|---|
| 1 | Gleason Grade 1 |
| 2 | Gleason Grade 2 |
| 3 | Gleason Grade 3 |
| 4 | Gleason Grade 4 |
| 5 | Gleason Grade 5 |
| 999 | Unknown |

**GatewayName:** TertiaryGleasonGrade

| ID #: | **4014** |
|---|---|
| **Question Text:** | **Is the baseline (prior to the initiation of treatment) Prostate Specific Antigen (PSA) value known?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single |

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** BaselinePSAValueKnown

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| ID #: | **4015** |
|---|---|
| **Question Text:** | **What was the baseline PSA value prior to the initiation of treatment?** |
| **Instructions:** | **This field is required.** |
| | For assays with a lower limit of detection equal to 0.2 ng/mL, if the value is undetectable, "Less than 0.2 ng/mL" should be entered. |
| | Appears only if BaselinePSAValueKnown = "Yes". |
| **Type / Length / Format:** | Text: Supported LOINC Codes: |
| | 2857-1 Prostate specific Ag [Mass/volume] in Serum or Plasma |
| | 35741-8 Prostate specific Ag [Mass/volume] in Serum or Plasma by Detection limit = 0.01 ng/mL |
| | 19197-3 Prostate specific Ag [Molecules/volume] in Serum or Plasma |
| | 19195-7 Prostate specific Ag [Units/volume] in Serum or Plasma |
| **Permissible Values:** | Must be a decimal value or the text string "Less than 0.2 ng/mL" |
| **GatewayName:** | BaselinePSAValue |

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| ID #: | **4016** |
|---|---|
| **Question Text:** | **What were the units of the baseline PSA value prior to the initiation of treatment?** |
| **Instructions:** | Choose one. |
| | Appears only if BaselinePSAValueKnown = "Yes". |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | ng/mL |
| 2 | ug/L |
| 3 | umol/L |
| 4 | U/L |
| 5 | ng/dL |

| **GatewayName:** | BaselinePSAUnits |
|---|---|

---

| ID #: | **4017** |
|---|---|
| **Question Text:** | What was the date of the baseline PSA value prior to the initiation of treatment? |
| **Instructions:** | Use the format 'MM/DD/YYYY'. |
| | Appears only if BaselinePSAValueKnown = "Yes". |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | BaselinePSADate |

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| | |
|---|---|
| **Data Entry Form:** | **Treatment Course** |
| Module Name | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once at the time of initial patient submission |
| Revision Date: | August 23, 2013 |
| Special Note: | Separate treatment course forms should be completed for each radiation therapy prescription. |

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| | |
|---|---|
| **ID #:** | **5001** |
| **Question Text:** | **Who was the treating physician at the start of the treatment course?** |
| **Instructions:** | |
| **Type / Length / Format:** | Text |
| **Permissible Values:** | n/a |
| **GatewayName:** | TreatingPhysician |

| | |
|---|---|
| **ID #:** | **5002** |
| **Question Text:** | **What type of radiation therapy was used in this treatment course?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio – Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| C15751 | External Beam Radiation Therapy |
| C15195 | Brachytherapy |

| | |
|---|---|
| **GatewayName:** | RadiationTherapyType |

| | |
|---|---|
| **ID #:** | **5003** |
| **Question Text:** | **What was the date of the first fraction of therapy (from all prescriptions) in this treatment course?** |
| **Instructions:** | **This field is required.** Enter the date in the format MM/DD/YYYY. |
| **Type / Length / Format:** | Date / MM-DD-YYYY |
| **Permissible Values:** | n/a |
| **GatewayName:** | CourseStartDate |

| | |
|---|---|
| **ID #:** | **5004** |
| **Question Text:** | **What was the date of the last fraction of therapy (from all prescriptions) in this treatment course?** |
| **Instructions:** | **This field is required.** Enter the date in the format MM/DD/YYYY. |
| **Type / Length / Format:** | Date / MM-DD-YYYY |
| **Permissible Values:** | n/a |
| **GatewayName:** | CourseEndDate |

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| | |
|---|---|
| **ID #:** | **5005** |
| **Question Text:** | **What was the patient's height in inches at the start of this treatment course?** |
| **Instructions:** | |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | PatientHeight |

| | |
|---|---|
| **ID #:** | **5006** |
| **Question Text:** | **What was the patient's weight in pounds at the start of this treatment course?** |
| **Instructions:** | |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | PatientWeight |

| | |
|---|---|
| **ID #:** | **5007** |
| **Question Text:** | **What was the patient's performance status at the start of this treatment course? Use the Karnofsky Performance Scale criteria.** |
| **Instructions:** | Choose one.<br>The Eastern Cooperative Oncology Group (ECOG) equivalent scores are indicated for ease of translation between the two scoring systems. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 100 | 100 - Normal; no complaints; no evidence of disease (ECOG 0) |
| 90 | 90 - Able to carry on normal activity; minor signs or symptoms of disease (ECOG 0) |
| 80 | 80 - Normal activity with effort; some sign or symptoms of disease (ECOG 1) |
| 70 | 70 - Cares for self; unable to carry on normal activity or do active work (ECOG 1) |
| 60 | 60 - Requires occasional assistance, but is able to care for most personal needs (ECOG 2) |
| 50 | 50 - Requires considerable assistance and frequent medical care (ECOG 2) |
| 40 | 40 - Disabled; requires special care and assistance (ECOG 3) |
| 30 | 30 - Severely disabled; hospitalization is indicated, although death not imminent (ECOG 3) |
| 20 | 20 - Very sick; hospitalization necessary; active support treatment is necessary (ECOG 4) |
| 10 | 10 - Moribund; fatal processes progressing rapidly (ECOG 4) |
| 0 | 0 - Dead (ECOG 5) |

**GatewayName:** PerformanceStatusTreatmentStart

| | |
|---|---|
| **ID #:** | **5008** |
| **Question Text:** | **Was androgen deprivation therapy used in conjunction with this treatment course?** |
| **Instructions:** | **This field is required.** Choose One. |
| **Type / Length / Format:** | Radio - Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes – prescribed by radiation oncologist |
| 2 | Yes – prescribed by referring provider |
| 999 | Unknown |

**GatewayName:** ADTUsed

| | |
|---|---|
| **ID #:** | **5009** |
| **Question Text:** | **What was the planned duration of the androgen deprivation therapy?** |
| **Instructions:** | **This field is required.** Choose one. Appears only if ADTUsed = "Yes". |
| **Type / Length / Format:** | Radio - Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | < 6 months |
| 2 | 6 – 11 months |
| 3 | 12 – 24 months |
| 4 | > 24 months |
| 5 | Indefinite |
| 999 | Unknown |

**GatewayName:** ADTDuration

| | |
|---|---|
| **ID #:** | **5010** |
| **Question Text:** | **Were any urinary toxicities (see definition) assessed on treatment?** |
| **Instructions:** | **This field is required.** |

Choose one.

"Urinary toxicities" include the following terms as defined in CTCAE v4.0:

Urinary tract pain – A disorder characterized by a sensation of marked discomfort in the urinary tract.

Urinary frequency – A disorder characterized by urination at short intervals.

Urinary urgency – A disorder characterized by a sudden compelling urge to urinate.

Urinary incontinence – A disorder characterized by inability to control the flow of urine from the bladder.

Urinary retention – A disorder characterized by accumulation of urine within the bladder because of the inability to urinate.

Hematuria – A disorder characterized by laboratory test results that indicate blood in the urine.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** UrinaryToxicityAssessed

| | |
|---|---|
| **ID #:** | **5011** |
| **Question Text:** | **Did the patient experience any Grade 3 or higher urinary toxicity (see definition) during the on-treatment period?** |
| **Instructions:** | **This field is required.** |

Choose one.

Appears only if UrinaryToxicityAssessed = "Yes".

"Grade 3 urinary toxicities" include the following as defined in CTCAE v4.0:

Urinary tract pain - Severe pain; limiting self care activities of daily living (ADL)

Urinary incontinence - Intervention indicated (e.g., clamp, collagen injections); operative intervention indicated; limiting self care ADL

Urinary retention - Elective operative or radiologic intervention indicated; substantial loss of affected kidney function or mass

Hematuria - Gross hematuria; transfusion, IV medications or hospitalization indicated; elective endoscopic, radiologic or operative intervention indicated; limiting self-care ADL

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** UrinaryGrade3Toxicity

|  | **ID #:** | **5012** |
|---|---|---|

**Question Text:** **Did the patient experience any Grade 2 urinary toxicity (see definition) during the on-treatment period?**

**Instructions:** This field is required.
Choose one.
Appears only if UrinaryToxicityAssessed = "Yes".
"Grade 2 urinary toxicities" include the following as defined in CTCAE v4.0:

> Urinary tract pain -- Moderate pain; limiting instrumental activities of daily living (ADL)
> Urinary frequency – Limiting instrumental ADL; medical management indicated
> Urinary urgency – Limiting instrumental ADL; medical management indicated
> Urinary incontinence – Spontaneous; pads indicated; limiting instrumental ADL
> Urinary retention – Placement of urinary, suprapubic or intermittent catheter placement indicated; medication indicated
> Hematuria – Symptomatic; urinary catheter or bladder irrigation indicated; limiting instrumental ADL

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** UrinaryGrade2Toxicity

|  | **ID #:** | **5013** |
|---|---|---|

**Question Text:** **Were any rectal toxicities (see definition) assessed on treatment?**

**Instructions:** This field is required.
Choose one.
"Rectal toxicities" include the following terms as defined in CTCAE v4.0:

> Rectal pain – A disorder characterized by a sensation of marked discomfort in the rectal region.
> Rectal hemorrhage – A disorder characterized by bleeding from the rectal wall and discharged from the anus.
> Rectal mucositis – A disorder characterized by inflammation of the mucous membrane of the rectum.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** RectalToxicityAssessed

| | |
|---|---|
| **ID #:** | **5014** |
| **Question Text:** | **Did the patient experience any Grade 3 or higher rectal toxicity (see definition) during the on-treatment period?** |
| **Instructions:** | **This field is required.**<br>Choose one.<br>Appears only if RectalToxicityAssessed = "Yes".<br>"Grade 3 rectal toxicities" include the following as defined in CTCAE v4.0:<br>    Rectal pain – Severe pain; limiting self care activities of daily living (ADL)<br>    Rectal hemorrhage – Transfusion, radiologic, endoscopic, or elective operative intervention indicated<br>    Rectal mucositis – Severe symptoms; limiting self-care ADL |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | RectalGrade3Toxicity |

| | |
|---|---|
| **ID #:** | **5015** |
| **Question Text:** | **Did the patient experience any Grade 2 rectal toxicity (see definition) during the on-treatment period?** |
| **Instructions:** | **This field is required.**<br>Choose one.<br>Appears only if RectalToxicityAssessed = "Yes".<br>"Grade 2 rectal toxicities" include the following as defined in CTCAE v4.0:<br>    Rectal pain – Moderate pain; limiting instrumental activities of daily living (ADL)<br>    Rectal hemorrhage – Moderate symptoms; medical intervention or minor cauterization indicated<br>    Rectal mucositis – Symptomatic; medical intervention indicated; limiting instrumental ADL |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | RectalGrade2Toxicity |

| | |
|---|---|
| **ID #:** | **5016** |
| **Question Text:** | **What was the prostate volume in mL at the time of treatment planning?** |
| **Instructions:** | |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | ProstateVolume |

**ID #:** 5017

**Question Text:** **What options were discussed during the initial patient consultation?**

**Instructions:** **This field is required.**
Check all that apply.
This information may be found in the consult note.

**Type / Length / Format:** Checkbox - multiple

**Permissible Values:**

| Code | Description |
|------|-------------|
| 1 | Surgical treatment options |
| 2 | Alternative radiation treatment options |
| 3 | Hormonal therapy |
| 4 | Active surveillance |

**GatewayName:** Discussion

| Data Entry Form: | EBRT Prescription |
|---|---|
| | Appears only if RadiationTherapyType on Treatment Course Form = "External Beam Radiation Therapy" |
| Module Name: | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once per prescription at the time of initial patient submission |
| Revision Date: | August 23, 2013 |

**ID #: 6001**

**Question Text:** **Indicate the external beam radiation treatment type for this prescription.**

**Instructions:** **This field is required.**
Choose one.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | Photon Beam |
| 2 | Proton Beam |
| 3 | Cobalt-60 Gamma Ray |

**GatewayName:** EBRTType

**ID #: 6002**

**Question Text:** **Indicate the planning method used for this prescription.**

**Instructions:** Choose one.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | 3-Dimensional Conformal Radiation Therapy |
| 2 | Intensity Modulated Radiation Therapy (IMRT) |
| 3 | Volume Modulated Arc Therapy (VMAT) |
| 4 | Scanned proton beam planning |
| 5 | Scattered proton beam planning |

**GatewayName:** EBRTPlanning

**ID #: 6003**

**Question Text:** **Indicate the delivery method used for this prescription.**

**Instructions:** Choose one.

**Type / Length / Format:** Radio - Single

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | C-arm Linear Accelerator |
| 2 | O-ring Treatment Machines (e.g. Tomotherapy) |
| 3 | Robotic Linear Accelerator (e.g. Cyberknife) |
| 4 | Scanned proton beam |
| 5 | Scattered proton beam |
| 6 | MR-based treatment machine (e.g. ViewRay) |

**GatewayName:** EBRTDelivery

| | |
|---|---|
| **ID #:** | **6004** |
| **Question Text:** | **What was the external beam maximum energy in MV?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Number |
| **Permissible Values:** | n/a |
| **GatewayName:** | EBRTMaxEnergy |

| | |
|---|---|
| **ID #:** | **6005** |
| **Question Text:** | **What was the total prescribed dose to the clinical target volume (CTV) in Gy?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Number |
| **Permissible Values:** | n/a |
| **GatewayName:** | CTVDose |

| | |
|---|---|
| **ID #:** | **6006** |
| **Question Text:** | **Indicate the intended external beam clinical target volume (CTV).** |
| **Instructions:** | **This field is required.** If more than one prescription/plan is used in this treatment course (e.g. a boost to the prostate), complete an additional EBRT form.  Please note that "Prostate Gland, Seminal Vesicles, and Pelvic Nodes" should be selected for any treatment to the whole pelvis. Choose one. |
| **Type / Length / Format:** | Radio – Single |
| **Permissible Values:** | |
| **GatewayName:** | CTVVolume |

| Code | Description |
|---|---|
| 1 | Prostate Gland only |
| 2 | Prostate Gland and Seminal Vesicles (>0.1cm) |
| 3 | Prostate Gland, Seminal Vesicles, and Pelvic Lymph Nodes (aka "Whole Pelvis") |

| | |
|---|---|
| **ID #:** | **6007** |
| **Question Text:** | **What was the total number of fractions prescribed for this treatment course?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | TotalFractionsPrescribed |

| | |
|---|---|
| **ID #:** | **6008** |
| **Question Text:** | **What was the number of fractions per day prescribed for this treatment course?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | DailyFractionsPrescribed |

| | |
|---|---|
| **ID #:** | **6009** |
| **Question Text:** | **What was the total number of fractions delivered for this treatment course?** |
| **Instructions:** | **This field is required.** |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | TotalFractionsDelivered |

| | |
|---|---|
| **ID #:** | **6010** |
| **Question Text:** | **Was any immobilization used for this prescription?** |
| **Instructions:** | Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** ImmobilizationUsed

| | |
|---|---|
| **ID #:** | **6011** |
| **Question Text:** | **Select all immobilization techniques used for this external beam prescription.** |
| **Instructions:** | Check all that apply. Appears only if ImmobilizationUsed = "Yes". |
| **Type / Length / Format:** | Checkboxes – Multiple |

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | Body Mould |
| 2 | Rectal Balloon |
| 3 | Leg Fixation |
| 888 | Other (specify) |

**GatewayName:** ImmobilizationTechniquesUsed

| | |
|---|---|
| **ID #:** | **6012** |
| **Question Text:** | **Specify the "Other" immobilization technique used for this external beam prescription.** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short / |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherImmobilizationUsed |

| | |
|---|---|
| **ID #:** | **6013** |
| **Question Text:** | **Indicate the primary target localization method used for this prescription.** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | None |
| 1 | Anatomic landmarks with film portal imaging |
| 2 | Anatomic landmarks with 2D kV/MV electronic portal imaging |
| 3 | Fiducial markers with film portal imaging |
| 4 | Fiducial markers with 2D kV/MV electronic portal imaging |
| 5 | Fiducial markers with cone beam CT |
| 6 | 3D kV CT imaging |
| 7 | 3D MV CT imaging |
| 8 | Radio beacon (e.g. Calypso) |
| 9 | Ultrasound |
| 888 | Other (specify) |

| | |
|---|---|
| **GatewayName:** | TargetLocalizationMethodUsed |

| | |
|---|---|
| **ID #:** | **6014** |
| **Question Text:** | **Specify the "Other" target localization method used for this prescription.** |
| **Instructions:** | Appears only when "other" is selected in previous question. |
| **Type / Length / Format:** | Text / Short |
| **Permissible Values:** | n/a |
| **GatewayName:** | OtherTargetLocalizationUsed |

| | |
|---|---|
| **ID #:** | **6015** |
| **Question Text:** | **Indicate the frequency of target localization.** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | None |
| 1 | Daily |
| 2 | Weekly |

| | |
|---|---|
| **GatewayName:** | TargetLocalizationFrequency |

| | |
|---|---|
| **Form Name:** | **Brachytherapy Prescription** |
| | Appears only if Radiation Therapy on Treatment Course Form = "Brachytherapy." |
| Module Name: | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once per prescription at the time of Initial patient submission |
| Revision Date: | August 23, 2013 |

| | |
|---|---|
| **ID #:** | **7001** |
| **Question Text:** | **Indicate the type of brachytherapy prescription.** |
| **Instructions:** | Choose one. |
| **Type / Length / Format:** | Radio - Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | Low dose rate (LDR) brachytherapy |
| 2 | High dose rate (HDR) brachytherapy |

| | |
|---|---|
| **GatewayName:** | BrachyPrescriptionType |
| **ID #:** | **7002** |
| **Question Text:** | **What was the brachytherapy prescription dose to the prostate – entire gland (Gy)?** |
| **Instructions:** | |
| **Type / Length / Format:** | Text |
| **Permissible Values:** | n/a |
| **GatewayName:** | BrachyDosePrescribed |
| **ID #:** | **7003** |
| **Question Text:** | **Indicate the brachytherapy planning technique.** |
| **Instructions:** | Choose one |
| **Type / Length / Format:** | Radio – Single |
| **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | Pre-operative |
| 2 | Intra-operative |

| | |
|---|---|
| **GatewayName:** | BrachyPlanningTechnique |

| | ID #: | **7004** |
|---|---|---|
| | **Question Text:** | **Indicate the type of imaging used for brachytherapy planning.** |
| | **Instructions:** | Choose one. |
| | **Type / Length / Format:** | Radio – Single |
| | **Permissible Values:** | |

| Code | Description |
|---|---|
| 0 | None |
| 1 | TRUS |
| 2 | CT |
| 3 | MRI |
| 888 | Other |
| 999 | Unknown |

**GatewayName:** BrachyPlanningImaging

| | ID #: | **7005** |
|---|---|---|
| | **Question Text:** | **Indicate the type of imaging used during the implant procedure.** |
| | **Instructions:** | Check all that apply. |
| | **Type / Length / Format:** | Checkboxes / Multiple |
| | **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | TRUS |
| 2 | CT |
| 3 | MRI |
| 4 | Fluoroscopy |

**GatewayName:** BrachyProcedureImaging

| | ID #: | **7006** |
|---|---|---|
| | **Question Text:** | **Indicate the isotope that was used for this low dose rate (LDR) brachytherapy prescription.** |
| | **Instructions:** | Choose one. Appears only if BrachyPrescriptionType = "LDR". |
| | **Type / Length / Format:** | Radio - Single |
| | **Permissible Values:** | |

| Code | Description |
|---|---|
| 1 | Iodine 125 |
| 2 | Palladium 103 |
| 3 | Gold 198 |
| 4 | Cesium (Cs) 131 |

**GatewayName:** LDRModality

| | ID #: | **7007** |
|---|---|---|
| | **Question Text:** | **How many sources were placed for this low dose rate (LDR) brachytherapy prescription?** |
| | **Instructions:** | Appears only if BrachyPrescriptionType = "LDR" |
| | **Type / Length / Format:** | Integer |
| | **Permissible Values:** | n/a |

**GatewayName:** LDRSeedNumber

**ID #:** 7008

**Question Text:** Indicate the type of sources placed for this low dose rate (LDR) brachytherapy prescription.

**Instructions:** Choose one.
Appears only if BrachyPrescriptionType = "LDR".

**Type / Length / Format:** Radio - Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 1 | Stranded |
| 2 | Loose |
| 3 | Both |

**GatewayName:** LDRSeedType

---

**ID #:** 7009

**Question Text:** What was the date of the first fraction implantation?

**Instructions:** Enter the date in the format MM/DD/YYYY.
Appears only if BrachyPrescriptionType = "LDR".

**Type / Length / Format:** Date / 'MM/DD/YYYY'

**Permissible Values:** n/a

**GatewayName:** LDRImplantDate

---

**ID #:** 7010

**Question Text:** Was post-implant dosimetry performed?

**Instructions:** This field is required.
Choose one.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** PostImplantDosimetry

---

**ID #:** 7011

**Question Text:** Indicate the imaging modality used for post-implant dosimetry.

**Instructions:** This field is required.
Choose one.
Appears only if PostImplantDosimetry = "Yes".

**Type / Length / Format:** Radio - Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 1 | TRUS |
| 2 | CT |
| 3 | MRI |

**GatewayName:** PostImplantImaging

---

| | |
|---|---|
| **ID #:** | **7012** |
| **Question Text:** | **What was the date of the post-implant dosimetry?** |
| **Instructions:** | **This field is required.**<br>Enter the date in the format MM/DD/YYYY.<br>Appears only if PostImplantDosimetry = "Yes". |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | PostImplantDosimetryDate |

| | |
|---|---|
| **ID #:** | **7013** |
| **Question Text:** | **How many HDR fractions were prescribed?** |
| **Instructions:** | Appears only if BrachyPrescriptionType = "HDR" |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | HDRFractions |

| | |
|---|---|
| **ID #:** | **7014** |
| **Question Text:** | **What was the HDR dose per fraction in Gy?** |
| **Instructions:** | Appears only if BrachyPrescriptionType = "HDR". |
| **Type / Length / Format:** | Integer |
| **Permissible Values:** | n/a |
| **GatewayName:** | HDRDosePerFraction |

| | |
|---|---|
| **ID #:** | **7015** |
| **Question Text:** | **What was the date of the first HDR fraction implantation?** |
| **Instructions:** | Enter the date in the format MM/DD/YYYY.<br>Appears only if BrachyPrescriptionType = "HDR". |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | FirstHDRFractionDate |

| Data Entry Form: | **Patient Cause of Death** |
| --- | --- |
| | Appears only if PatientStatus = "Deceased." |
| Module Name: | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | N/A |
| Revision Date: | August 23, 2013 |

| | |
| --- | --- |
| **ID #:** | **8001** |
| **Question Text:** | **What was the date of death?** |
| **Instructions:** | **This field is required.** |
| | Enter the date in the format MM/DD/YYYY. |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | DeathDate |

| | | |
| --- | --- | --- |
| **ID #:** | **8002** | |
| **Question Text:** | **What was the primary cause of death?** | |
| **Instructions:** | **This field is required.** | |
| | Choose one. | |
| **Type / Length / Format:** | Radio – Single | |
| **Permissible Values:** | Code | Description |
| | 1 | Malignant Cancer |
| | 2 | Non-Cancerous Disease |
| | 999 | Unknown |
| **GatewayName:** | DeathCause | |

| | | |
| --- | --- | --- |
| **ID #:** | **8003** | |
| **Question Text:** | **Please select the cancer that was the primary cause of death.** | |
| **Instructions:** | Choose one. | |
| | Coded according to the SEER Cause of Death Recode 1969+ (04/16/2012). Appears only if DeathCause = "Malignant Cancer". | |
| **Type / Length / Format:** | Dropdown List | |
| **Permissible Values:** | 35011 | Acute Lymphocytic Leukemia |
| | 35031 | Acute Monocytic Leukemia |
| | 35021 | Acute Myeloid Leukemia |
| | 35043 | Aleukemic, subleukemic and NOS |
| | 21060 | Anus, Anal Canal and Anorectum |
| | 23000 | Bones and Joints |
| | 31010 | Brain and Other Nervous System |
| | 26000 | Breast |
| | 27010 | Cervix Uteri |
| | 35012 | Chronic Lymphocytic Leukemia |
| | 35022 | Chronic Myeloid Leukemia |
| | 21040 | Colon excluding Rectum |
| | 27020 | Corpus Uteri |

| | |
|---|---|
| 21010 | Esophagus |
| 30000 | Eye and Orbit |
| 20040 | Floor of Mouth |
| 21080 | Gallbladder |
| 20050 | Gum and Other Mouth |
| 33010 | Hodgkin Lymphoma |
| 20090 | Hypopharynx |
| 21072 | Intrahepatic Bile Duct |
| 36020 | Kaposi Sarcoma |
| 29020 | Kidney and Renal Pelvis |
| 22020 | Larynx |
| 20010 | Lip |
| 21071 | Liver |
| 22030 | Lung and Bronchus |
| 25010 | Melanoma of the Skin |
| 36010 | Mesothelioma |
| 37000 | Miscellaneous Malignant Cancer |
| 34000 | Myeloma |
| 20060 | Nasopharynx |
| 33040 | Non-Hodgkin Lymphoma |
| 22010 | Nose, Nasal Cavity and Middle Ear |
| 20080 | Oropharynx |
| 35041 | Other Acute Leukemia |
| 21090 | Other Biliary |
| 21130 | Other Digestive Organs |
| 32020 | Other Endocrine including Thymus |
| 27070 | Other Female Genital Organs |
| 35013 | Other Lymphocytic Leukemia |
| 28040 | Other Male Genital Organs |
| 35023 | Other Myeloid/Monocytic Leukemia |
| 25020 | Other Non-Epithelial Skin |
| 20100 | Other Oral Cavity and Pharynx |
| 29040 | Other Urinary Organs |
| 27040 | Ovary |
| 21100 | Pancreas |
| 28030 | Penis |
| 21120 | Peritoneum, Omentum and Mesentery |
| 22050 | Pleura |
| 28010 | Prostate |
| 21050 | Rectum and Rectosigmoid Junction |
| 21110 | Retroperitoneum |
| 20030 | Salivary Gland |
| 21030 | Small Intestine |
| 24000 | Soft Tissue including Heart |
| 21020 | Stomach |
| 28020 | Testis |
| 32010 | Thyroid |
| 20020 | Tongue |

| 20070 | Tonsil |
|---|---|
| 22060 | Trachea, Mediastinum and Other Respiratory Organs |
| 29030 | Ureter |
| 29010 | Urinary Bladder |
| 27030 | Uterus, NOS |
| 27050 | Vagina |
| 27060 | Vulva |

**GatewayName:** CancerDeathCause

**ID #:** 8004

**Question Text:** **Please select the non-cancerous disease that was the primary cause of death.**

**Instructions:** Choose one.
Coded according to the SEER Cause of Death Recode 1969+ (04/16/2012). Appears only if DeathCause = "Non-Cancerous Disease".

**Type / Length / Format:** Dropdown List

**Permissible Values:**

| 50210 | Accidents and Adverse Effects |
|---|---|
| 50051 | Alzheimer's (ICD-9 and 10 only) |
| 50100 | Aortic Aneurysm and Dissection |
| 50090 | Atherosclerosis |
| 50080 | Cerebrovascular Diseases |
| 50190 | Certain Conditions Originating in Perinatal Period |
| 50150 | Chronic Liver Disease and Cirrhosis |
| 50130 | Chronic Obstructive Pulmonary Disease and Allied Conditions |
| 50170 | Complications of Pregnancy, Childbirth, Puerperium |
| 50180 | Congenital Anomalies |
| 50050 | Diabetes Mellitus |
| 50060 | Diseases of Heart |
| 50230 | Homicide and Legal Intervention |
| 50040 | Human Immunodeficiency Virus (HIV) (1987+) |
| 50070 | Hypertension without Heart Disease |
| 38000 | In situ, benign or unknown behavior neoplasm |
| 50160 | Nephritis, Nephrotic Syndrome and Nephrosis |
| 50300 | Other Cause of Death |
| 50110 | Other Diseases of Arteries, Arterioles, Capillaries |
| 50040 | Other Infectious and Parasitic Diseases |
| 50120 | Pneumonia and Influenza |
| 50030 | Septicemia |
| 50140 | Stomach and Duodenal Ulcers |
| 50220 | Suicide and Self-Inflicted Injury |
| 50200 | Symptoms, Signs and Ill-Defined Conditions |
| 50010 | Syphilis |
| 50000 | Tuberculosis |

**GatewayName:** NonCancerDeathCause

| Data Entry Form: | **Prostate Cancer Follow-up** |
| --- | --- |
| Module Name | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Yearly following the initial submission |
| Revision Date: | August 23, 2013 |

| | |
| --- | --- |
| **ID #:** | **9001** |
| **Question Text:** | **Has the patient had any follow-up visits with Radiation Oncology at this facility in the past year?** |
| **Instructions:** | **This field is required.** Choose one. |
| **Type / Length / Format:** | Radio - Single |
| **Permissible Values:** | |

| Code | Description |
| --- | --- |
| 0 | No |
| 1 | Yes |

| | |
| --- | --- |
| **GatewayName:** | RadOncFollowUp |
| **ID #:** | **9002** |
| **Question Text:** | **Has the patient had any follow-up visits with other specialties in the past year for which documentation is available at this facility? Check all that apply.** |
| **Instructions:** | **This field is required.** Check all that apply. |
| **Type / Length / Format:** | Checkboxes / Multiple |
| **Permissible Values:** | |

| Code | Description |
| --- | --- |
| 1 | Medical Oncology |
| 2 | Urology |
| 3 | Primary Care |
| 888 | Other |

| | |
| --- | --- |
| **GatewayName:** | OtherFollowUpVisit |
| **ID #:** | **9003** |
| **Question Text:** | **What is the date of the most recent follow-up visit for which documentation is available?** |
| **Instructions:** | **This field is required.** Enter the date in the format MM/DD/YYYY. |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | DateofLastFollowUp |

| | |
|---|---|
| **ID #:** | **9004** |
| **Question Text:** | **What is the patient's status?** |
| **Instructions:** | **This field is required.** |
| | Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | Living |
| 2 | Lost to Follow-up |
| 3 | Subject Withdrew |
| 4 | Deceased |

| | |
|---|---|
| **GatewayName:** | PatientStatus |

| | |
|---|---|
| **ID #:** | **9005** |
| **Question Text:** | **Has the patient been diagnosed with a biochemical recurrence since the initial course of treatment?** |
| **Instructions:** | Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 666 | Indeterminate/Equivocal |
| 999 | Unknown |

| | |
|---|---|
| **GatewayName:** | BiochemicalRecurrenceStatus |

| | |
|---|---|
| **ID #:** | **9006** |
| **Question Text:** | **What was the diagnosis date of biochemical recurrence?** |
| **Instructions:** | Enter the date in the format MM/DD/YYYY. |
| | Appears only if BiochemicalRecurrenceStatus = "Yes". |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | BiochemicalRecurrenceDate |

| | |
|---|---|
| **ID #:** | **9007** |
| **Question Text:** | **Has the patient been diagnosed with a local recurrence since the initial course of treatment?** |
| **Instructions:** | Choose one. |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 666 | Indeterminate/Equivocal |
| 999 | Unknown |

| | |
|---|---|
| **GatewayName:** | LocalRecurrenceStatus |

| | |
|---|---|
| **ID #:** | **9008** |
| **Question Text:** | **What was the diagnosis date of the local recurrence?** |
| **Instructions:** | Enter the date in the format MM/DD/YYYY.<br>Appears only if LocalRecurrenceStatus = "Yes". |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | LocalRecurrenceDiagnosisDate |

| | |
|---|---|
| **ID #:** | **9009** |
| **Question Text:** | **What was the method of evaluation of the local recurrence?** |
| **Instructions:** | Check all that apply.<br>Appears only if LocalRecurrenceStatus = "Yes". |
| **Type / Length / Format:** | Checkbox - Multiple |

| **Permissible Values:** | Code | Description |
|---|---|---|
| | 1 | Clinical Exam |
| | 2 | Imaging |
| | 3 | Biopsy |

| | |
|---|---|
| **GatewayName:** | LocalRecurrenceEvaluation |

| | |
|---|---|
| **ID #:** | **9010** |
| **Question Text:** | **Has the patient been diagnosed with distant progression since the initial course of treatment?** |
| **Instructions:** | Choose one. |
| **Type / Length / Format:** | Radio - single |

| **Permissible Values:** | Code | Description |
|---|---|---|
| | 0 | No |
| | 1 | Yes |
| | 666 | Indeterminate/Equivocal |
| | 999 | Unknown |

| | |
|---|---|
| **GatewayName:** | DistantProgressionStatus |

| | |
|---|---|
| **ID #:** | **9011** |
| **Question Text:** | **What was the diagnosis date of distant progression?** |
| **Instructions:** | Enter the date in the format MM/DD/YYYY.<br>Appears only if DistantProgressionStatus = "Yes". |
| **Type / Length / Format:** | Date / 'MM/DD/YYYY' |
| **Permissible Values:** | n/a |
| **GatewayName:** | DistantProgressionDiagnosisDate |

---

**ID #: 9012**

**Question Text: Indicate all known sites of distant progression.**

**Instructions:** Check all that apply.
Appears only if DistantProgressionStatus = "Yes".

**Type / Length / Format:** Checkbox – Multiple

**Permissible Values:**

| Code | Description |
|------|-------------|
| 1 | Bone |
| 2 | Lymph Node |
| 3 | Other Visceral Organs |

**GatewayName:** DistantProgressionSite

---

**ID #: 9013**

**Question Text: What was the method of evaluation used to diagnose the distant progression?**

**Instructions:** Check all that apply.
Appears only if DistantProgressionStatus = "Yes".

**Type / Length / Format:** Checkbox – Multiple

**Permissible Values:**

| Code | Description |
|------|-------------|
| 1 | Clinical Exam |
| 2 | Imaging |
| 3 | Biopsy |

**GatewayName:** DistantProgressionEvaluation

---

**ID #: 9014**

**Question Text: Is the patient currently on androgen deprivation therapy?**

**Instructions:** Choose one.
Appears only if ADTUsed = "Yes".

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** CurrentADT

---

| | ID #: | 9015 |
|---|---|---|
| **Question Text:** | What was the reason androgen deprivation therapy was discontinued? | |

**Instructions:** Choose one.
Appears only if CurrentADT = "No".

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | Treatment completed as prescribed |
| 2 | Treatment terminated due to toxicity |
| 3 | Patient request |
| 888 | Other |

**GatewayName:** ADTDiscontinuationReason

---

| | ID #: | 9016 |
|---|---|---|
| **Question Text:** | Is the patient receiving any secondary prostate cancer therapy? | |

**Instructions:** Choose one.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** SecondaryTherapy

---

| | ID #: | 9017 |
|---|---|---|
| **Question Text:** | What was the type of secondary therapy prescribed? | |

**Instructions:** Choose one.
Appears only if SecondaryTherapy = "Yes".

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 1 | Palliative radiation therapy for metastatic disease |
| 2 | Re-treatment of progressive local disease with external beam radiation |
| 3 | Re-treatment of progressive local disease with brachytherapy |
| 4 | Re-treatment of progressive local disease with cryotherapy / hifu |
| 5 | Chemotherapy |
| 6 | Immunotherapy |
| 7 | Novel alternative hormonal therapy |
| 8 | Additional hormonal therapy |
| 9 | Radiopharmaceuticals |
| 888 | Other |

**GatewayName:** SecondaryTherapyType

---

---

**ID #: 9018**

**Question Text: Indicate the secondary therapy start date.**

**Instructions:** Enter the date in the format MM/DD/YYYY.
Appears only if SecondaryTherapy = "Yes".

**Type / Length / Format:** Date / 'MM/DD/YYYY'

**Permissible Values:** n/a

**GatewayName:** SecondaryTherapyStartDate

---

**ID #: 9019**

**Question Text: What was the maximum PSA value since the last follow-up submission?**

**Instructions:** For assays with a lower limit of detection equal to 0.2 ng/mL, if the value is undetectable, "Less than 0.2 ng/mL" should be entered.

**Type / Length / Format:** Text
Supported LOINC Codes:
2857-1 Prostate specific Ag [Mass/volume] in Serum or Plasma
35741-8 Prostate specific Ag [Mass/volume] in Serum or Plasma by Detection limit = 0.01 ng/mL
19197-3 Prostate specific Ag [Molecules/volume] in Serum or Plasma
19195-7 Prostate specific Ag [Units/volume] in Serum or Plasma

**Permissible Values:** Must be a decimal value or the text string "Less than 0.2ng/ mL."

**GatewayName:** FollowUpPSAValue

---

**ID #: 9020**

**Question Text: What were the units of the maximum PSA value obtained since the last follow-up submission?**

**Instructions:** Choose one.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 1 | ng/mL |
| 2 | ug/L |
| 3 | umol/L |
| 4 | U/L |
| 5 | ng/dL |

**GatewayName:** FollowUpPSAUnits

---

**ID #: 9021**

**Question Text: What was the date of the maximum PSA value since the last follow-up submission?**

**Instructions:** Enter the date in the format MM/DD/YYYY.

**Type / Length / Format:** Date / 'MM/DD/YYY'

**Permissible Values:** n/a

**GatewayName:** FollowUpPSADate

---

|  |  |
|---|---|
| **ID #:** | **9022** |
| **Question Text:** | **Were any urinary toxicities (see definition) assessed since the last follow-up submission?** |
| **Instructions:** | <span style="color:red">**This field is required.**</span><br>Choose one.<br>"Urinary toxicities" include the following terms as defined in CTCAE v4.0:<br>Urinary tract pain – A disorder characterized by a sensation of marked discomfort in the urinary tract.<br>Urinary frequency – A disorder characterized by urination at short intervals.<br>Urinary urgency – A disorder characterized by a sudden compelling urge to urinate.<br>Urinary incontinence – A disorder characterized by inability to control the flow of urine from the bladder.<br>Urinary retention – A disorder characterized by accumulation of urine within the bladder because of the inability to urinate.<br>Hematuria – A disorder characterized by laboratory test results that indicate blood in the urine. |

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** FollowUpUrinaryToxicityAssessed

| | |
|---|---|
| **ID #:** | **9023** |
| **Question Text:** | **Did the patient experience any Grade 3 or higher urinary toxicity (see definition) since the last follow-up submission?** |
| **Instructions:** | **This field is required.**<br>Choose one.<br>Appears only if FollowUpUrinaryToxicityAssessed = "Yes".<br>"Grade 3 urinary toxicities" include the following as defined in CTCAE v4.0:<br>Urinary tract pain - Severe pain; limiting self care activities of daily living (ADL)<br>Urinary incontinence - Intervention indicated (e.g., clamp, collagen injections); operative intervention indicated; limiting self care ADL<br>Urinary retention - Elective operative or radiologic intervention indicated; substantial loss of affected kidney function or mass<br>Hematuria - Gross hematuria; transfusion, IV medications or hospitalization indicated; elective endoscopic, radiologic or operative intervention indicated; limiting self-care ADL |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | FollowUpUrinaryGrade3Toxicity |

| | |
|---|---|
| **ID #:** | **9024** |
| **Question Text:** | **Did the patient experience any Grade 2 urinary toxicity (see definition) since the last follow-up submission?** |
| **Instructions:** | **This field is required.**<br>Choose one.<br>Appears only if FollowUpUrinaryToxicityAssessed = "Yes".<br>"Grade 2 urinary toxicities" include the following as defined in CTCAE v4.0:<br>Urinary tract pain -- Moderate pain; limiting instrumental activities of daily living (ADL)<br>Urinary frequency – Limiting instrumental ADL; medical management indicated<br>Urinary urgency – Limiting instrumental ADL; medical management indicated<br>Urinary incontinence – Spontaneous; pads indicated; limiting instrumental ADL<br>Urinary retention – Placement of urinary, suprapubic or intermittent catheter placement indicated; medication indicated<br>Hematuria – Symptomatic; urinary catheter or bladder irrigation indicated; limiting instrumental ADL |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

| | |
|---|---|
| **GatewayName:** | FollowUpUrinaryGrade2Toxicity |

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**ID #:** 9025

**Question Text:** **Were any rectal toxicities (see definition) assessed since the last follow-up submission?**

**Instructions:** **This field is required.**
Choose one.
"Rectal toxicities" include the following terms as defined in CTCAE v4.0:
Rectal pain – A disorder characterized by a sensation of marked discomfort in the rectal region.
Rectal hemorrhage – A disorder characterized by bleeding from the rectal wall and discharged from the anus.
Rectal mucositis – A disorder characterized by inflammation of the mucous membrane of the rectum.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |
| 999 | Unknown |

**GatewayName:** FollowUpRectalToxicityAssessed

---

**ID #:** 9026

**Question Text:** **Did the patient experience any Grade 3 or higher rectal toxicity (see definition) since the last follow-up submission?**

**Instructions:** **This field is required.**
Choose one.
Appears only if FollowUpRectalToxicityAssessed = "Yes".
"Grade 3 rectal toxicities" include the following as defined in CTCAE v4.0:
Rectal pain – Severe pain; limiting self-care activities of daily living (ADL)
Rectal hemorrhage – Transfusion, radiologic, endoscopic, or elective operative intervention indicated
Rectal mucositis – Severe symptoms; limiting self-care ADL

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** FollowUpRectalGrade3Toxicity

---

**ID #:** 9027

**Question Text:** **Did the patient experience any Grade 2 rectal toxicity (see definition) since the last follow-up submission?**

**Instructions:** <span style="color:red">**This field is required.**</span>
Choose one.
Appears only if FollowUpRectalToxicityAssessed = "Yes".
"Grade 2 rectal toxicities" include the following as defined in CTCAE v4.0:
　　Rectal pain – Moderate pain; limiting instrumental activities of daily living (ADL)
　　Rectal hemorrhage – Moderate symptoms; medical intervention or minor cauterization indicated
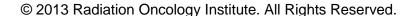　　Rectal mucositis – Symptomatic; medical intervention indicated; limiting instrumental ADL

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** FollowUpRectalGrade2Toxicity

| | |
|---|---|
| **Data Entry Form:** | **Charlson Comorbidity Index (CCI)** |
| Module Name: | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once at the time of initial patient submission |
| Revision Date: | August 23, 2013 |

**ID #: 10001**

**Question Text:** **What was the patient's age at the start of this treatment course?**

**Instructions:** Choose one.

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | Less than 40 years |
| 1 | 41 to 50 years |
| 2 | 51 to 60 years |
| 3 | 61 to 70 years |
| 4 | 71 to 80 years |
| 5 | 81 to 90 years |
| 6 | 91 to 100 years |

**GatewayName:** CCI_AgeAtStartofTreatmentCourse

**ID #: 10002**

**Question Text:** **As of the start of this treatment course, please indicate if the patient had a history of myocardial infarction.**

**Instructions:** Choose one.
Corresponding Diagnosis Codes:
ICD-9-CM: 410.x, 412.x

ICD-10: 121.x, 122.x, 125.2

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_MI

---

**ID #:** **10003**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of congestive heart failure.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:

ICD-9-CM: 398.91, 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 425.4–425.9, 428.x

ICD-10: I09.9, I11.0, I13.0, I13.2, I25.5, I42.0, I42.5–I42.9, I43.x, I50.x, P29.0

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_CHF

---

**ID #:** **10004**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of peripheral vascular disease.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:

ICD-9-CM: 093.0, 437.3, 440.x, 441.x, 443.1–443.9, 47.1, 557.1, 557.9, V43.4

ICD-10: I70.x, I71.x, I73.1, I73.8, I73.9, I77.1, I79.0, I79.2, K55.1, K55.8, K55.9, Z95.8, Z95.9

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_PVD

---

**ID #:** **10005**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of cerebrovascular disease.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:

ICD-9-CM: 362.34, 430.x–438.x

ICD-10: G45.x, G46.x, H34.0, I60.x–I69.x

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_CVD

---

**ID #: 10006**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of dementia.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:

ICD-9-CM: 290.x, 294.1, 331.2

ICD-10: F00.x–F03.x, F05.1, G30.x, G31.1

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_Dementia

---

**ID #: 10007**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of chronic pulmonary disease.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:

ICD-9-CM: 416.8, 416.9, 490.x–505.x, 506.4, 508.1, 508.8

ICD-10: I27.8, I27.9, J40.x–J47.x, J60.x–J67.x, J68.4, J70.1, J70.3

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_COPD

---

**ID #: 10008**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of connective tissue disease.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:

ICD-9-CM: 446.5, 710.0–710.4, 714.0–714.2, 714.8, 725.x

ICD-10: M05.x, M06.x, M31.5, M32.x–M34.x, M35.1, M35.3, M36.0

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_ConnectiveTissue

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| | |
|---|---|
| **ID #:** | **10009** |
| **Question Text:** | **As of the start of this treatment course, please indicate whether the patient had a history of ulcer disease.** |
| **Instructions:** | Choose one. Corresponding Diagnosis Codes:<br><br>ICD-9-CM: 531.x–534.x<br><br>ICD-10: K25.x–K28.x |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Yes |

**GatewayName:** CCI_PUD

| | |
|---|---|
| **ID #:** | **10010** |
| **Question Text:** | **As of the start of this treatment course, please indicate whether the patient had a history of liver disease.** |
| **Instructions:** | Choose one. Corresponding Diagnosis Codes:<br>Mild:<br>ICD-9-CM: 070.22, 070.23, 070.32, 070.33, 070.44, 070.54, 070.6, 070.9, 570.x, 571.x, 573.3, 573.4, 573.8, 573.9, V42.7<br><br>ICD-10: B18.x, K70.0–K70.3, K70.9, K71.3–K71.5, K71.7, K73.x, K74.x, K76.0, K76.2–K76.4, K76.8, K76.9, Z94.4<br><br>Moderate or severe:<br>ICD-9-CM: 456.0–456.2, 572.2–572.8<br><br>ICD-10: I85.0, I85.9, I86.4, I98.2, K70.4, K71.1, K72.1, K72.9, K76.5, K76.6, K76.7 |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Mild |
| 3 | Moderate to Severe |

**GatewayName:** CCI_Liver

| | |
|---|---|
| **ID #:** | **10011** |
| **Question Text:** | **As of the start of this treatment course, please indicate whether the patient had a history of diabetes.** |
| **Instructions:** | Choose one. Corresponding Diagnosis Codes: <br> Without chronic complications: <br> ICD-9-CM: 250.0–250.3, 250.8, 250.9 <br><br> ICD-10: E10.0, E10.1, E10.6, E10.8, E10.9, E11.0, E11.1, E11.6, E11.8, E11.9, E12.0, E12.1, E12.6, E12.8, E12.9, E13.0, E13.1, E13.6, E13.8, E13.9, E14.0, E14.1, E14.6, E14.8, E14.9 <br><br> With chronic complications: <br> ICD-9-CM: 250.4–250.7 <br><br> ICD-10: E10.2–E10.5, E10.7, E11.2–E11.5, E11.7, E12.2–E12.5, E12.7, E13.2–E13.5, E13.7, E14.2–E14.5, E14.7 |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 1 | Without chronic complications |
| 2 | With chronic complications |

**GatewayName:** CCI_DM

| | |
|---|---|
| **ID #:** | **10012** |
| **Question Text:** | **As of the start of this treatment course, please indicate whether the patient had a history of hemiplegia or paraplegia.** |
| **Instructions:** | Choose one. Corresponding Diagnosis Codes: <br> ICD-9-CM: 334.1, 342.x, 343.x, 344.0–344.6, 344.9 <br><br> ICD-10: G04.1, G11.4, G80.1, G80.2, G81.x, G82.x, G83.0–G83.4, G83.9 |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 2 | Yes |

**GatewayName:** CCI_Hemiplegia

**ID #:** **10013**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of chronic kidney disease.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:
Moderate or severe:
ICD-9-CM: 403.01, 403.11, 403.91, 404.02, 404.03, 404.12, 404.13, 404.92, 404.93, 582.x, 583.0–583.7, 585.x, 586.x, 588.0, V42.0, V45.1, V56.x

ICD-10: I12.0, I13.1, N03.2–N03.7, N05.2–N05.7, N18.x, N19.x, N25.0, Z49.0–Z49.2, Z94.0, Z99.2

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No or mild |
| 2 | Moderate or severe |

**GatewayName:** CCI_CKD

---

**ID #:** **10014**

**Question Text:** **As of the start of this treatment course, please indicate whether the patient had a history of solid tumor malignancy.**

**Instructions:** Choose one. Corresponding Diagnosis Codes:
Not metastatic:
ICD-9-CM: 140.x–172.x, 174.x–195.8

ICD-10: C00.x–C26.x, C30.x–C34.x, C37.x–C41.x, C43.x, C45.x–C58.x, C60.x–C76.x

Metastatic:
ICD-9-CM: 196.x–199.x

ICD-10: C77.x–C80.x

**Type / Length / Format:** Radio – Single

**Permissible Values:**

| Code | Description |
|------|-------------|
| 0 | No |
| 2 | Non-metastatic |
| 6 | Metastatic |

**GatewayName:** CCI_SolidTumor

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| | |
|---|---|
| **ID #:** | **10015** |
| **Question Text:** | **As of the start of this treatment course, please indicate whether the patient had a history of leukemia or lymphoma.** |
| **Instructions:** | Choose one. Corresponding Diagnosis Codes: |
| | ICD-9-CM: 200.x–208.x, 238.6 |
| | ICD-10: C81.x–C85.x, C88.x, C90.x–C97.x |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 2 | Yes |

**GatewayName:** CCI_HemeMalignancy

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| | |
|---|---|
| **ID #:** | **10016** |
| **Question Text:** | **As of the start of this treatment course, please indicate whether the patient had a history of HIV/AIDS.** |
| **Instructions:** | Choose one. Corresponding Diagnosis Codes: |
| | ICD-9-CM: 042.x–044.x |
| | ICD-10: B20.x–B22.x, B24.x |
| **Type / Length / Format:** | Radio – Single |

**Permissible Values:**

| Code | Description |
|---|---|
| 0 | No |
| 6 | Yes |

**GatewayName:** CCI_AIDS

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| | |
|---|---|
| **Form Name:** | **DVH Summary Statistics** |
| Module Name: | NROR Patient Module |
| Parent Entity: | Patient |
| Submission Frequency: | Once at the time of Initial patient submission |
| Revision Date: | August 23, 2013 |

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**ID #:** **11001**

**Question Text:** **What dose did 95% of the clinical target volume (CTV D95) receive in Gy?**

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** CTV_D95

---

**ID #:** **11002**

**Question Text:** **What dose did 90% of the clinical target volume (CTV D90) receive in Gy?**

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** CTV_D90

---

**ID #:** **11003**

**Question Text:** **What was the CTV Mean Dose in Gy?**

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** CTVMeanDose

---

**ID #:** **11004**

**Question Text:** **What was the CTV maximum dose in Gy?**

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** CTVMaxDose

---

**ID #:** **11005**

**Question Text:** **What was the CTV minimum dose in Gy?**

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** CTVMinDose

---

**ID #:** 11006

**Question Text:** What volume of the bladder received 70 Gy in cc?

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** BladderV70cc

---

**ID #:** 11007

**Question Text:** What percentage of the bladder received 70 Gy?

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** BladderV70Percent

---

**ID #:** 11008

**Question Text:** What volume of the bladder received 40 Gy in cc?

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** BladderV40cc

---

**ID #:** 11009

**Question Text:** What percentage of the bladder received 40 Gy?

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** BladderV40Percent

---

**ID #:** 11010

**Question Text:** What volume of the rectum received 70 Gy in cc?

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** RectumV70cc

---

**ID #:** 11011

**Question Text:** What percentage of the rectum received 70 Gy?

**Instructions:**

**Type / Length / Format:** Numeric

**Permissible Values:** n/a

**GatewayName:** RectumV70Percent

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| | |
|---|---|
| **ID #:** | **11012** |
| **Question Text:** | **What volume of the rectum received 40 Gy in cc?** |
| **Instructions:** | |
| **Type / Length / Format:** | Numeric |
| **Permissible Values:** | n/a |
| **GatewayName:** | RectumV40cc |

| | |
|---|---|
| **ID #:** | **11013** |
| **Question Text:** | **What percentage of the rectum received 40 Gy?** |
| **Instructions:** | |
| **Type / Length / Format:** | Numeric |
| **Permissible Values:** | n/a |
| **GatewayName:** | RectumV40Percent |