



Sister Study Breast Cancer Medical Report Form

Patient Name: _____

Date of Birth: / /
mm/dd/yyyy

Date this form completed: / /
mm/dd/yyyy

Doctor(s) and Address: *(please print)*

Doctor's Name: _____ Phone: () _____

Doctor's Name: _____ Phone: () _____

Affiliation: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Who Completed This Form? *(please print)*

Name: _____ Phone: () _____

INSTRUCTIONS: Please provide a copy of the breast cancer medical reports listed below and check the corresponding box. Also, please fill in as much of the attached form as possible. Please return the medical reports and this form within the next **30 days** using the enclosed addressed envelope. Thank you!

Have you enclosed a copy of the following medical reports?

- | | | | |
|--|--------------------------|--------------------------|--|
| Please provide or correct pathologist information below. | Yes | No | <input type="checkbox"/> <input type="checkbox"/> (1) Pathology report from the breast biopsy; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (2) Pathology report from the lumpectomy/mastectomy; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (3) Pathology report from the lymph node dissection; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (4) Estrogen and progesterone receptor assay report; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (5) Narrative discharge summary for the relevant admission(s); |
| | <input type="checkbox"/> | <input type="checkbox"/> | (6) HER2NEU test results; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (7) Treatment Plan and/or summary; |
| | <input type="checkbox"/> | <input type="checkbox"/> | (8) Other relevant records. |

Name of Pathologist(s)/Lab: _____ Phone: () _____

Name of Pathologist(s)/Lab: _____ Phone: () _____

Address: _____

City/Town: _____ State: _____ Zip: _____

For Office Use Only: Date of Receipt _____ / _____ / _____ SIS ID #: _____

1. Date of Breast Cancer Diagnosis: ____/____/____
mm/dd/yyyy

2. Total number of tumors: _____

Instructions: Please complete one column of the Tumor Characteristics grid for each individual tumor per breast cancer diagnosis. If there was one tumor - complete column one only, two tumors - complete two columns only, and so forth.

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
3. Pathology Accession Number(s)	_____ _____ _____	_____ _____ _____	_____ _____ _____
4. Type	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented
5. Location	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented
6. Laterality	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented
7. Quadrant Location	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
8. Evidence of Lymphatic-Vascular Invasion (LVI)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented
9. Tumor Size (single longest dimension in cm)	_____ . _____ cm	_____ . _____ cm	_____ . _____ cm
10. Method of Determination of Tumor Size	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented

Tumor 4	Tumor 5	Tumor 6
_____ _____ _____	_____ _____ _____	_____ _____ _____
<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive: _____% <input type="checkbox"/> In situ: _____% <input type="checkbox"/> Not documented
<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented	<input type="checkbox"/> Ductal <input type="checkbox"/> Lobular <input type="checkbox"/> Mixed—ductal dominant <input type="checkbox"/> Mixed—lobular dominant <input type="checkbox"/> No primary location evident <input type="checkbox"/> Not documented
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Not documented
<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Upper outer quadrant <input type="checkbox"/> Lower outer quadrant <input type="checkbox"/> Upper inner quadrant <input type="checkbox"/> Lower inner quadrant <input type="checkbox"/> Central <input type="checkbox"/> Nipple <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Uncertain <input type="checkbox"/> Not documented
_____ . _____ cm	_____ . _____ cm	_____ . _____ cm
<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented	<input type="checkbox"/> Pathology <input type="checkbox"/> Mammography <input type="checkbox"/> Clinically <input type="checkbox"/> Not documented

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
11. Tumor Histology - Ductal	<input type="checkbox"/> Invasive Ductal NOS <input type="checkbox"/> Invasive Ductal with Lobular Tendencies <input type="checkbox"/> Mucinous <input type="checkbox"/> Medullary <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Inflammatory <input type="checkbox"/> Comedo <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Ductal NOS <input type="checkbox"/> Invasive Ductal with Lobular Tendencies <input type="checkbox"/> Mucinous <input type="checkbox"/> Medullary <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Inflammatory <input type="checkbox"/> Comedo <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Ductal NOS <input type="checkbox"/> Invasive Ductal with Lobular Tendencies <input type="checkbox"/> Mucinous <input type="checkbox"/> Medullary <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Inflammatory <input type="checkbox"/> Comedo <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
12. Tumor Histology -Lobular	<input type="checkbox"/> Invasive Lobular NOS <input type="checkbox"/> Invasive Lobular Classic <input type="checkbox"/> Invasive Lobular Pleomorphic <input type="checkbox"/> Invasive Lobular with Ductal Tendencies <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Lobular NOS <input type="checkbox"/> Invasive Lobular Classic <input type="checkbox"/> Invasive Lobular Pleomorphic <input type="checkbox"/> Invasive Lobular with Ductal Tendencies <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Lobular NOS <input type="checkbox"/> Invasive Lobular Classic <input type="checkbox"/> Invasive Lobular Pleomorphic <input type="checkbox"/> Invasive Lobular with Ductal Tendencies <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
13. Grade 1 = predominately well-differentiated 2 = moderately differentiated/balanced pattern 3 = poorly differentiated ND = not documented	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____
14. Estrogen Receptor Assay (ERA) Type	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
15. Estrogen Receptor Assay (ERA) Results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
16. ERA Value	ERA Value: _____	ERA Value: _____	ERA Value: _____
17. Progesterone Receptor Assay (PRA) Type	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented

Tumor 4	Tumor 5	Tumor 6
<input type="checkbox"/> Invasive Ductal NOS <input type="checkbox"/> Invasive Ductal with Lobular Tendencies <input type="checkbox"/> Mucinous <input type="checkbox"/> Medullary <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Inflammatory <input type="checkbox"/> Comedo <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Ductal NOS <input type="checkbox"/> Invasive Ductal with Lobular Tendencies <input type="checkbox"/> Mucinous <input type="checkbox"/> Medullary <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Inflammatory <input type="checkbox"/> Comedo <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Ductal NOS <input type="checkbox"/> Invasive Ductal with Lobular Tendencies <input type="checkbox"/> Mucinous <input type="checkbox"/> Medullary <input type="checkbox"/> Papillary <input type="checkbox"/> Tubular <input type="checkbox"/> Inflammatory <input type="checkbox"/> Comedo <input type="checkbox"/> Cribriform <input type="checkbox"/> Solid <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
<input type="checkbox"/> Invasive Lobular NOS <input type="checkbox"/> Invasive Lobular Classic <input type="checkbox"/> Invasive Lobular Pleomorphic <input type="checkbox"/> Invasive Lobular with Ductal Tendencies <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Lobular NOS <input type="checkbox"/> Invasive Lobular Classic <input type="checkbox"/> Invasive Lobular Pleomorphic <input type="checkbox"/> Invasive Lobular with Ductal Tendencies <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented	<input type="checkbox"/> Invasive Lobular NOS <input type="checkbox"/> Invasive Lobular Classic <input type="checkbox"/> Invasive Lobular Pleomorphic <input type="checkbox"/> Invasive Lobular with Ductal Tendencies <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Not documented
Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____	Overall grade _____ Nuclear grade _____ Tubular grade _____ Mitotic grade _____
<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
ERA Value: _____	ERA Value: _____	ERA Value: _____
<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Biochemical <input type="checkbox"/> Immunohistochemical (ERICA) <input type="checkbox"/> Immunofluorescent <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented

Tumor Characteristic	Tumor 1	Tumor 2	Tumor 3
18. Progesterone Receptor Assay (PRA) Results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
19. PRA Value	PRA Value: _____	PRA Value: _____	PRA Value: _____
20. HER-2/NEU Assay Type	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
21. Results of HER-2/NEU	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
22. HER-2/NEU Value (IHC only)	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
23. DNA Ploidy	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
24. S-Phase	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented

Tumor 4	Tumor 5	Tumor 6
<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Borderline/marginal <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
PRA Value: _____	PRA Value: _____	PRA Value: _____
<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Immunohistochemistry (IHC) <input type="checkbox"/> FISH, gene amplification <input type="checkbox"/> Both IHC and FISH <input type="checkbox"/> Not performed <input type="checkbox"/> Not documented
<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Overexpressed <input type="checkbox"/> Not overexpressed <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> 0 <input type="checkbox"/> +1 <input type="checkbox"/> +2 <input type="checkbox"/> +3 <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Diploid/Euploid/Normal (DNA Index 1.0) <input type="checkbox"/> Aneuploid/Abnormal (DNA Index>1.0) <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented
<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented	<input type="checkbox"/> Low (or < reference) <input type="checkbox"/> Intermediate <input type="checkbox"/> High (or > reference) <input type="checkbox"/> Equivocal <input type="checkbox"/> Specify percentage: _____% <input type="checkbox"/> Test not done <input type="checkbox"/> Not documented

Surgical Treatment

	Left Breast	Right Breast
25. Date of post-diagnosis surgery	____/____/____ mm/dd/yyyy	____/____/____ mm/dd/yyyy
26. Type of surgery	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented	<input type="checkbox"/> Lumpectomy <input type="checkbox"/> Other Breast Conserving Therapy (BCT) <input type="checkbox"/> Mastectomy <input type="checkbox"/> No post-diagnosis surgery performed <input type="checkbox"/> Not documented

Lymph Node Involvement and Metastatic Results

27. Lymph Node Involvement (Sentinel lymph node biopsy and final surgery combined)

Number sampled: _____

Number malignant: _____

28. Results of Metastatic Work Up:

- | | |
|--|--|
| <input type="checkbox"/> Completely negative | <input type="checkbox"/> Work up not performed |
| <input type="checkbox"/> Incomplete or equivocal | <input type="checkbox"/> Not documented |
| <input type="checkbox"/> Metastatic at diagnosis | |

Chemotherapy Treatment

29. Neo-adjuvant (pre-surgery) chemotherapy for breast cancer: Yes
 No
 Not documented

30. If yes,

Chemotherapy Regimen (see list below)	# Cycles	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Mark if therapy on-going	Prescribed dosing interval
<i>Example: ATC</i>	<i>2</i>	<i>02/01/2006</i>	<i>02/15/2006</i>	<input type="checkbox"/>	<i>q 2 weeks</i>
				<input type="checkbox"/>	
				<input type="checkbox"/>	

31. Adjuvant chemotherapy for breast cancer: Yes
 No
 Not documented

32. If yes,

Chemotherapy Regimen (see list below)	# Cycles	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Mark if therapy on-going	Prescribed dosing interval
<i>Example: CMF</i>	<i>4</i>	<i>03/01/2006</i>		<input checked="" type="checkbox"/>	<i>q 2 weeks</i>
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	
				<input type="checkbox"/>	

LIST OF CHEMOTHERAPY REGIMENS FOR QUESTIONS 30 & 32:

AC—Adriamycin/Cytoxan	EC - Epirubicin/Cytoxan
AT—Adriamycin/Taxol	Td—Taxotere
ATC—Adriamycin/Taxol or Taxotere/Cytoxan	FEC—Fluorouracil/Epirubicin/Cytoxan
T—Taxol	T+H—Taxol plus Herceptin
CMF—Cytoxan/Methotrexate/Fluorouracil	Abraxane
CAF/FAC—Cytoxan/Adriamycin/Fluorouracil	Other—please specify

Biological Treatment

33. Herceptin treatment for breast cancer? Yes
 No
 Not documented

34. If yes,

Drug Name	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Mark if therapy on-going
			<input type="checkbox"/>
			<input type="checkbox"/>

Hormonal Treatment

35. Hormonal treatments such as tamoxifen, raloxifene, or aromatase inhibitors [Arimidex (Anastrozole), Femara (Letrozole), Aromasin (Exemestane)]? Yes
 No
 Not documented

36. If yes,

(If dose changed, enter on a separate line)

Drug Name	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Dosage	Mark if therapy on-going
				<input type="checkbox"/>

Radiation Treatment

37. Radiation therapy: Yes
 No
 Not documented

38. If yes,

Target Site of Radiation Treatment	Left Breast				Right Breast			
	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Mark if therapy on-going	Cumulative Dose (cGy)	Start date mm/dd/yyyy	End date mm/dd/yyyy (if known)	Mark if therapy on-going	Cumulative Dose (cGy)
Whole Breast	____/____/____	____/____/____	<input type="checkbox"/>		____/____/____	____/____/____	<input type="checkbox"/>	
Tumor Bed	____/____/____	____/____/____	<input type="checkbox"/>		____/____/____	____/____/____	<input type="checkbox"/>	
Chest Wall	____/____/____	____/____/____	<input type="checkbox"/>		____/____/____	____/____/____	<input type="checkbox"/>	
Supraclavicular (SCV)	____/____/____	____/____/____	<input type="checkbox"/>		____/____/____	____/____/____	<input type="checkbox"/>	
Axilla	____/____/____	____/____/____	<input type="checkbox"/>		____/____/____	____/____/____	<input type="checkbox"/>	
Intramammary nodes (IMN)	____/____/____	____/____/____	<input type="checkbox"/>		____/____/____	____/____/____	<input type="checkbox"/>	

Clinical Trial Enrollment

39. Enrolled in a clinical trial for breast cancer treatment/management: Yes
 No
 Not documented

40. If yes,

Name or ID number of trial: _____

Treatment(s) or procedure(s) tested: _____

Treatment(s) or procedure(s) patient received as part of the trial (if known): _____

Sponsor of trial (e.g. NIH, CALGB): _____

41. Did patient complete the trial?: Completed Did not complete, dropped out
 Ongoing Not documented

Genetic Testing

42. BRCA1 Genetic testing: Positive
Specify Variant: _____ Equivocal
Specify Variant: _____
 Negative Test not done
 Not documented

43. BRCA2 Genetic testing: Positive
Specify Variant: _____ Equivocal
Specify Variant: _____
 Negative Test not done
 Not documented

44. Other Genetic testing:

Type: _____

Result: _____

Molecular Profiling

45. Molecular Profiling and Proliferation assay: Yes
 No
 Not documented

46. If yes,

Assay Type (e.g. MammaPrint, OncotypeDx, MIB-1, E-cadherin)	Score