Sister Study Breast Cancer Master File
Cover Sheet for Medical Report Form
Version 9

SIS ID:

Date of Diagnosis:  

Report Changes

- New Report
- Attached with additions
- Attached with changes
- No additions or changes

Report Status

- Interim
- Final
- Refused

Last Date on Medical Records/Pathology Report:  

Origin (1=HCP, 2=Woman):

Record Type (1=Medical Records, 2=Pathology Report, 3=Both):

Point of Contact (1=Oncologist, 2=Surgeon, 3=Radiologist, 4=Pathologist, 5=Other):

Cancer Type (6=Breast Cancer):

Date of Abstraction:  

Completed Sections:

- 1. Tumor Characteristics and Surgery
- 2. Lymph Node Involvement and Metastatic Results
- 3. Chemotherapy Treatment
- 4. Biological Treatment
- 5. Hormonal Treatment
- 6. Radiation Treatment
- 7. Clinical Trial Enrollment
- 8. Treatment Side Effects
- 9. Genetic Testing
- 10. Other Molecular Profiling
- 11. ALL RECORDED

Validation

Data Retrieval

11/10/16
Date of Birth: ______ / ______ / ______

Who completed this form? (please print name) ________________________________

Have you enclosed a copy of the following medical reports?

- Pathology report from the breast biopsy;
- Pathology report from the lumpectomy/mastectomy;
- Pathology report from the lymph node dissection;
- Estrogen and progesterone receptor assay report;
- Narrative discharge summary for the relevant admission(s);
- HER2NEU test results;
- Treatment Plan and/or summary;
- Other relevant records.

Name of Pathology Facility #1: _____________________________________________

Phone: ( ) ___________________________________________________________

Address: ______________________________________________________________

City/Town: ___________________________ State: __________ Zip: __________

Name of Pathology Facility #2: _____________________________________________

Phone: ( ) ___________________________________________________________

Address: ______________________________________________________________

City/Town: ___________________________ State: __________ Zip: __________
2. Weight prior to surgery and treatment (if n/a, use closest date available):  
Pounds: __________ 
Date: [mm] / [dd] / [yyyy]

3. Total number of tumors: __________

3a. Diagnostic histology (ICD-O-3/behavior):  
1. ____________________________
2. ____________________________
3. ____________________________

<table>
<thead>
<tr>
<th>Tumor Characteristic</th>
<th>Tumor 1</th>
<th>Tumor 2</th>
<th>Tumor 3</th>
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<td>Pathology accession number(s)</td>
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<td>4. __________________________</td>
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5. Type 
(MARK ALL THAT APPLY) 
☐ Invasive: _____%  
☐ In situ: _____%  
☐ Not documented

6. Invasive tumor size (single longest dimension in cm)  
_____ . _____ cm  
_____ . _____ cm  
_____ . _____ cm

7. In situ tumor size (single longest dimension in cm)  
_____ . _____ cm  
_____ . _____ cm  
_____ . _____ cm

7a. Method of determination of tumor size 
☐ Pathology  
☐ Mammography  
☐ Clinically  
☐ Not documented

8. Multifocal tumor 
☐ Yes  
☐ No  
☐ Not documented

9. Location 
☐ Ductal  
☐ Lobular  
☐ Mixed—ductal dominant  
☐ Mixed—lobular dominant  
☐ No primary location evident  
☐ Mixed—equal ductal and lobular  
☐ Not documented

10. Laterality 
☐ Right  
☐ Left  
☐ Not documented
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<tr>
<td>31. Date of <strong>FIRST</strong> post-diagnosis surgery</td>
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<td><em><strong><strong>/</strong></strong></em>/_______</td>
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<td>mm dd yyyy</td>
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<tr>
<td>32. Type of surgery</td>
<td>Lumpectomy</td>
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<tr>
<td></td>
<td>Other Breast Conserving Therapy (BCT)</td>
<td>Other Breast Conserving Therapy (BCT)</td>
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<td></td>
<td>Mastectomy</td>
<td>Mastectomy</td>
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<td></td>
<td>Re-excision</td>
<td>Re-excision</td>
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<td></td>
<td>Biopsy (entire tumor removed)</td>
<td>Biopsy (entire tumor removed)</td>
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<td>mm dd yyyy</td>
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<td>34. Type of surgery</td>
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<td>Other Breast Conserving Therapy (BCT)</td>
<td>Other Breast Conserving Therapy (BCT)</td>
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<td>Mastectomy</td>
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<td>Re-excision</td>
<td>Re-excision</td>
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<td></td>
<td>Biopsy (entire tumor removed)</td>
<td>Biopsy (entire tumor removed)</td>
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<td>35. Date of <strong>THIRD</strong> post-diagnosis surgery</td>
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<td>mm dd yyyy</td>
<td>mm dd yyyy</td>
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<td>Lumpectomy</td>
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<td></td>
<td>Other Breast Conserving Therapy (BCT)</td>
<td>Other Breast Conserving Therapy (BCT)</td>
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<td>Mastectomy</td>
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<td>Re-excision</td>
<td>Re-excision</td>
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<td>Biopsy (entire tumor removed)</td>
<td>Biopsy (entire tumor removed)</td>
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<td><em><strong><strong>/</strong></strong></em>/_______</td>
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<td>Re-excision</td>
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</tbody>
</table>
37. Closest final margin
   □ Positive  □ Negative
   If Negative, Specify Size: ______ __ . ______ __ cm

37a. Tumor found in last surgery
   □ Yes  □ No  □ Not documented

---

### Lymph Node Involvement and Metastatic Results

38. Lymph node involvement (Sentinel lymph node biopsy and final surgery combined)
   a. Number sampled: _______________
   b. Number malignant: ______________
   c. Node staging: ______________

39a. Results of metastatic work up at diagnosis:
   □ Completely negative
   □ Incomplete or equivocal
   □ Metastatic at diagnosis
   □ Work up not performed
   □ Not documented

39b. If metastatic at diagnosis, which distal sites were affected:
   □ Bone
   □ Brain
   □ Liver
   □ Lung
   □ Other
   Specify: ________________________
   □ Not documented

40a. Results of metastatic work up post diagnosis:
   □ Completely negative
   □ Incomplete or equivocal
   □ Metastatic post diagnosis
   □ Work up not performed
   □ Not documented

40b. If metastatic post diagnosis, which distal sites were affected:
   □ Bone
   □ Brain
   □ Liver
   □ Lung
   □ Other
   Specify: ________________________
   □ Not documented

40c. Date of metastatic workup post diagnosis:
   mm / dd / yyyy
**Chemotherapy Treatment**

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

42. If yes,

<table>
<thead>
<tr>
<th>Chemotherapy Regimen (see list below)</th>
<th># Cycles</th>
<th>Mark if therapy on-going</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Prescribed dosing interval</th>
<th>Completion Status</th>
</tr>
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<tbody>
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<td>Comp. Disc.</td>
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<td></td>
<td>Comp. Disc.</td>
</tr>
</tbody>
</table>

43. Adjuvant chemotherapy for breast cancer:
   - [ ] Yes
   - [ ] No
   - [ ] Not documented

44. If yes,

<table>
<thead>
<tr>
<th>Chemotherapy Regimen (see list below)</th>
<th># Cycles</th>
<th>Mark if therapy on-going</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Prescribed dosing interval</th>
<th>Completion Status</th>
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<td></td>
<td>Comp. Disc.</td>
</tr>
</tbody>
</table>

44x. Other Chemotherapy regimen (non-cytotoxic)
   - [ ] Yes
   - [ ] No
   - [ ] Not documented

If yes,

<table>
<thead>
<tr>
<th>Other Chemotherapy Regimen (non-cytotoxic)</th>
<th># Cycles</th>
<th>Mark if therapy on-going</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Prescribed dosing interval</th>
<th>Completion Status</th>
</tr>
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<td></td>
<td>Comp. Disc.</td>
</tr>
</tbody>
</table>
### Biological Therapy

45. Herceptin treatment or other biological treatment for breast cancer?

- □ Yes
- □ No
- □ Not documented

46. If yes,

*(If dose changed, enter on a separate line)*

<table>
<thead>
<tr>
<th>Drug Name</th>
<th># Cycles</th>
<th>Mark if therapy on-going</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Prescribed Dosing Interval</th>
<th>Completion Status</th>
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<td>4.</td>
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</table>

### Hormonal Treatment

47. Hormonal treatments such as tamoxifen, raloxifene, or aromatase inhibitors [Arimidex (Anastrozole), Femara (Letrozole), Aromasin (Exemestane)], Faslodex, or Megace?  

- □ Yes
- □ No
- □ Not documented

48. If yes,

*(If dose changed, enter on a separate line)*

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Mark if therapy on-going</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Dosage</th>
<th>Pre DX</th>
<th>Completion Status</th>
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</thead>
<tbody>
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<td>4.</td>
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</tbody>
</table>
### Radiation Treatment

**49. Radiation therapy:**  
☐ Yes  
☐ No  
☐ Not documented  

**49a. External radiation therapy:**  
☐ Yes  
☐ No  
☐ Not documented  

**50. If yes - External Radiation:**

<table>
<thead>
<tr>
<th>Target Site of Radiation Treatment</th>
<th>Completion Status</th>
<th>Mark if therapy ongoing</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Dose (cGy)</th>
<th>Mark if therapy ongoing</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Dose (cGy)</th>
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<tbody>
<tr>
<td>Whole Breast</td>
<td>Comp.</td>
<td>☐</td>
<td><strong>/</strong>_/</td>
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<td>☐</td>
<td><strong>/</strong>_/</td>
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<tr>
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<td>Disc.</td>
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<tr>
<td>Tumor Bed</td>
<td>Comp.</td>
<td>☐</td>
<td><strong>/</strong>_/</td>
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<td>☐</td>
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<tr>
<td>Chest Wall</td>
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<td>☐</td>
<td><strong>/</strong>_/</td>
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<td>☐</td>
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<tr>
<td>Supraclavicular (SCV)</td>
<td>Comp.</td>
<td>☐</td>
<td><strong>/</strong>_/</td>
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<td>Axilla</td>
<td>Comp.</td>
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<td><strong>/</strong>_/</td>
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<td>☐</td>
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<td>Intramammary nodes (IMN)</td>
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<td><strong>/</strong>_/</td>
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<td>Disc.</td>
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**51a. If yes to external radiation, was IMRT used:**  
☐ Yes  
☐ No  

**51. Internal radiation technique used:**  
☐ Yes, specify type: ______________________________

☐ No  
☐ Not documented
51b. If yes - Internal Radiation:

<table>
<thead>
<tr>
<th>Target Site of Radiation Treatment</th>
<th>Completion Status</th>
<th>Mark if therapy ongoing</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Dose (cGy)</th>
<th>Mark if therapy ongoing</th>
<th>Start date mm/dd/yyyy</th>
<th>End date mm/dd/yyyy (if known)</th>
<th>Dose (cGy)</th>
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</thead>
<tbody>
<tr>
<td>Tumor Bed</td>
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<tr>
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Clinical Trial Enrollment

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

53. 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): ____________________________

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

Treatment Side Effects

55. Treatment toxicity side effects present: □ Yes □ No □ Not documented

56. If yes, treatment toxicity side effects:
   □ Allergic reaction □ Thrombocytopenia
   □ Anemia □ Other
   □ Clinical cardiotoxicity
   □ Gastrointestinal
   □ Myalgia
   □ Neutropenia
   □ Neuropathy
   □ Osteodynia
   □ Arthralgia
   □ Leukopenia
### Genetic Testing

57. Genetic testing performed
- □ Yes
- □ No
- □ Test not done/Not documented
- □ Not documented

57x. BRCA1 Genetic testing:
(MARK ALL THAT APPLY)
- □ Positive
  - Specify Variant: _______________
- □ Equivocal
  - Specify Variant: _______________
- □ Negative
  - □ Test not done
  - □ Not documented

  57a. If done, how many sites: _______________

58x. BRCA2 Genetic testing:
(MARK ALL THAT APPLY)
- □ Positive
  - Specify Variant: _______________
- □ Equivocal
  - Specify Variant: _______________
- □ Negative
  - □ Test not done
  - □ Not documented

  58a. If done, how many sites: _______________

58x1. Other germline testing done (non-BRCA):
- □ Yes
- □ No
- □ Not documented

If yes,

<table>
<thead>
<tr>
<th></th>
<th>58x2. Were the results for this germline testing: (MARK ALL THAT APPLY)</th>
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<tr>
<td>FIRST TYPE:</td>
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<td></td>
<td>□ Positive, Specify Variant: _______________</td>
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<td>□ Equivocal, Specify Variant: _______________</td>
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<td>□ Equivocal, Specify Variant: _______________</td>
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Other Molecular Profiling

59. Molecular Profiling and Proliferation assay:  
☐ Yes  
☐ No  
☐ Not documented

60. If yes,

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