

2.2 ₂ Anaplastic Lymphoma Kinase [ALK] testing?Date of test: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Test results:

₀ Negative ₁ Positive ₂ Borderline ₉ Unknown₈ Other (Specify): _____2.3 ₃ Kirsten-ras protein [KRAS] testing?Date of test: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Test results:

₀ Negative ₁ Positive ₂ Borderline ₉ Unknown₈ Other (Specify): _____2.4 ₄ BRAF (V600E)Date of test: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Test results:

₀ Negative ₁ Positive ₂ Borderline ₉ Unknown₈ Other (Specify): _____2.5 ₅ KITDate of test: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Test results:

₀ Negative ₁ Positive ₂ Borderline ₉ Unknown₈ Other (Specify): _____2.6 ₆ PD-L1Date of test: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Test results:

₀ Negative ₁ Positive ₂ Borderline ₉ Unknown₈ Other (Specify): _____2.7 ₇ ROS1Date of test: ___/___/___ ₁ Exact ₂ Estimated ₉ Unknown
Month Day Year

Test results:

₀ Negative ₁ Positive ₂ Borderline ₉ Unknown₈ Other (Specify): _____2.8 ₈₈ Other (Specify): _____

3. Was systemic chemotherapy and/or targeted or specialized therapy administered as part of the first course of therapy?

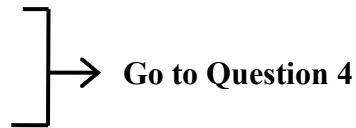
₁ Yes

₀ No



₂ Recommended, unknown if done

₉ Unknown



3.1	Regimen/Name: _____	Code: _____
Type: <input type="checkbox"/> ₁ Adjuvant therapy <input type="checkbox"/> ₂ Neoadjuvant therapy		
Start date: ____ / ____ / ____ <input type="checkbox"/> ₁ Exact <input type="checkbox"/> ₂ Estimated <input type="checkbox"/> ₉ Unknown <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>		
3.2	Regimen/Name: _____	Code: _____
Type: <input type="checkbox"/> ₁ Adjuvant therapy <input type="checkbox"/> ₂ Neoadjuvant therapy		
Start date: ____ / ____ / ____ <input type="checkbox"/> ₁ Exact <input type="checkbox"/> ₂ Estimated <input type="checkbox"/> ₉ Unknown <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>		
3.3	Regimen/Name: _____	Code: _____
Type: <input type="checkbox"/> ₁ Adjuvant therapy <input type="checkbox"/> ₂ Neoadjuvant therapy		
Start date: ____ / ____ / ____ <input type="checkbox"/> ₁ Exact <input type="checkbox"/> ₂ Estimated <input type="checkbox"/> ₉ Unknown <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>		
3.4	Regimen/Name: _____	Code: _____
Type: <input type="checkbox"/> ₁ Adjuvant therapy <input type="checkbox"/> ₂ Neoadjuvant therapy		
Start date: ____ / ____ / ____ <input type="checkbox"/> ₁ Exact <input type="checkbox"/> ₂ Estimated <input type="checkbox"/> ₉ Unknown <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>		
3.5	Regimen/Name: _____	Code: _____
Type: <input type="checkbox"/> ₁ Adjuvant therapy <input type="checkbox"/> ₂ Neoadjuvant therapy		
Start date: ____ / ____ / ____ <input type="checkbox"/> ₁ Exact <input type="checkbox"/> ₂ Estimated <input type="checkbox"/> ₉ Unknown <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>		
3.6	Regimen/Name: _____	Code: _____
Type: <input type="checkbox"/> ₁ Adjuvant therapy <input type="checkbox"/> ₂ Neoadjuvant therapy		
Start date: ____ / ____ / ____ <input type="checkbox"/> ₁ Exact <input type="checkbox"/> ₂ Estimated <input type="checkbox"/> ₉ Unknown <div style="display: flex; justify-content: space-around; font-size: small;"> Month Day Year </div>		

4. Was radiation therapy given as part of the first course of therapy to the primary tumor and/or a metastatic site?

₁ Yes

₀ No

₂ Recommended, unknown if done

₉ Unknown



} → Go to Question 5

4.1 Was radiation given as part of chemoradiation?

₁ Yes

₀ No

₉ Unknown



4.1.1 ₁ Concurrent

₂ Sequential

₉ Unknown/not specified

4.2 Specify where radiation was given (**Mark all that apply.**)

₁ Primary tumor

Metastatic Site:

₉ Unknown

₂ Bone

₃ Brain

₈ Metastatic site other (**Specify**): _____

4.3 What type of radiation was administered? (**Mark all that apply.**)

₁ External beam radiation therapy (EBRT)

₂ Internal radiation therapy (e.g., Brachytherapy)

₈ Other (**Specify**): _____

₉ Unknown

4.4 Start date: ____ / ____ / ____
Month Day Year

₁ Exact

₂ Estimated

₉ Unknown

End date: ____ / ____ / ____
Month Day Year

₁ Exact

₂ Estimated

₉ Unknown

Total dosage of radiation received: _____ cGy/Rad

₉ Unknown

