Change in Status Form - Version 1.0

This form should be completed by the physician or study coordinator whenever there is a change in patient status. Fold in half and seal this preaddressed, postpaid form and mail to the Data Coordinating Center. Please print or type. Thank You!

Physician Information

Surgeon of record for this patient's enrollment surgery

Neurosurgeon _____ _____
First Name Last Name

Hospital / Clinic _____

Address _____

City _____ State _____ Zip / Postal Code _____ - ____

Telephone Number (__ __ __) __ __ __ - __ __ __ __ Fax Number (__ __ __) __ __ __ - __ __ __ __

Patient Information

Date of completion __ __ / __ __ / __ __ (Today's Date)
month / day / year

Patient Name _____ _____ _____
First Name MI Last Name

Social Security Number __ __ __ - __ __ - __ __ __ __ (or Social Insurance Number in Canada)

☐ Patient has moved out of this area (Complete new address below if known)

☐ Change of address:

New address Street _____

City _____ State _____ ZIP / Postal Code _____

New Phone Number (__ __ __) __ __ __ - __ __ __ __

☐ Patient has been referred to

Dr. _____ _____ Phone (__ __ __) __ __ __ - __ __ __ __
First Name Last Name

Street _____

City _____ State _____ ZIP / Postal Code _____

☐ Patient has withdrawn from the **GO Project** because ☐ Unable to participate ☐ Unwilling to participate

☐ Patient has died Date __ __ / __ __ / __ __ ☐ Glioma-related ☐ Other cause of death ☐ Unknown
month / day / year

☐ Patient has been lost to follow-up

COMMENTS _____