Perioperative Form - Version 1.1

This form should be completed by a physician or study coordinator each time the patient has a biopsy or a craniotomy. Please print or type. Thank you!

Physician Information

Neurosurgeon _____ _____
First Name Last Name

Hospital / Clinic _____

Patient Information

Patient Name _____ _____ _____
First Name MI Last Name

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

1. Date of Completion (Today's Date)

__ __ / __ __ / __ __
month / day / year

2. Reason for Completion

☐ Biopsy only (burr hole or stereotatic)
☐ First craniotomy
☐ Second or subsequent craniotomy

	Yes	No*
Is this the patient's first operation (biopsy or craniotomy) for a brain tumor?	☐	☐

Please complete a **Retrospective Form if you are enrolling a patient at other than first biopsy or craniotomy.*

Preoperative Assessment

Please answer the questions below based on clinical findings relevant to CURRENT surgery

3. Presenting clinical findings

	Yes	No
Altered level of consciousness	☐	☐
Headache	☐	☐
Memory loss	☐	☐
Nausea/vomiting	☐	☐
Language deficit	☐	☐
Personality change	☐	☐
Progressive motor deficit	☐	☐
Seizures	☐	☐
Cognitive changes	☐	☐
Sensory symptoms	☐	☐
Papillaedema	☐	☐
Visual problems	☐	☐
Other	☐	☐

Specify_____

4. Time since onset of symptoms that led to current surgery

☐ <1 month
☐ 1-2 months
☐ 3-4 months
☐ 5-6 months
☐ 7-11 months
☐ 1-4 years
☐ ≥5 years
☐ No symptoms

5. Preop Karnofsky Performance Score (see reference guide)

__ __ __ (Range 0 - 100)

6. Neurodiagnostic studies relevant to current surgery

	Yes	No
CT-Brain	☐	☐
MR-brain	☐	☐
EEG	☐	☐
Angiography	☐	☐
Isotope-brain	☐	☐
PET scan	☐	☐
Functional MR scan	☐	☐
Skull X-ray	☐	☐
Other	☐	☐

Specify_____

Perioperative Summary

7. Tumor Characteristics

a. Number of tumor sites

☐ One
☐ Multifocal

b. Largest tumor diameter (on imaging study)

☐ <2cm
☐ 2-4cm
☐ >4cm

c. Did tumor enhance?

☐ Yes
☐ No

d. Tumor location

(Please select one location)

☐ Right
☐ Left
☐ Midline
☐ Bilateral

(Please check yes or no for each anatomic region)

	Yes	No
Frontal	☐	☐
Temporal	☐	☐
Parietal	☐	☐
Occipital	☐	☐
Basal ganglia	☐	☐
Supratentorial	☐	☐
Infratentorial	☐	☐
Cerebellum	☐	☐
Brain stem	☐	☐
Other	☐	☐

Specify_____

e. Tumor grade

☐ III
☐ IV
☐ Not graded (e.g. recurrent tumor)

f. Tumor pathology

☐ Glioblastoma multiforme
☐ Anaplastic astrocytoma
☐ Anaplastic oligodendroglioma
☐ Mixed anaplastic oligo/astrocytoma
☐ Other anaplastic glioma
Specify_____

8. Date of surgery

__ __ / __ __ / __ __
month / day / year

9. Date of admission to hospital

__ __ / __ __ / __ __
month / day / year

10. Date of discharge from hospital
(If patient died before discharge, please use date of death as date of discharge.)

__ __ / __ __ / __ __
month / day / year

11. Type of operation

(Please check yes or no for each type of operation)

	Yes	No
Image guided biopsy	☐	☐
Image guided resection	☐	☐
Craniotomy for biopsy	☐	☐
Craniotomy for subtotal resection	☐	☐
Craniotomy for gross total resection	☐	☐

12. Was cortical mapping used?

☐ Yes
☐ No

13. Were implantable carmustine wafers used?

☐ Yes (Specify #_____)
☐ No

14. Were radioactive seeds implanted?

- ☐ Permanent
- ☐ Temporary (removed within a few days or less)
- ☐ None

15. In-hospital prophylaxis against pulmonary embolism

	Yes	No	Unknown
Intermittent pneumatic compression	☐	☐	☐
Low molecular weight heparin	☐	☐	☐
Low dose standard heparin	☐	☐	☐
Elastic stockings	☐	☐	☐
Other	☐	☐	☐

Specify_____

16. Immediate discharge disposition

- ☐ Home (independent)
- ☐ Home (dependent)
- ☐ Rehabilitation unit
- ☐ Skilled nursing facility
- ☐ Expired
- ☐ Other (Specify_____)
- ☐ Unknown

17. **Medications**

	Preop	Postop 0-3 weeks	None
Glucocorticosteroids	☐	☐	☐
Anticonvulsants	☐	☐	☐
Antidepressants	☐	☐	☐

Specify_____

Antipsychotics	☐	☐	☐

Specify_____

Other	☐	☐	☐

Specify_____

18. Morbid events (from current surgery to first postop visit at 1-3 weeks postop)

	Yes	No	Unknown
Depression	☐	☐	☐
Deep vein thrombosis	☐	☐	☐
Intracranial hemorrhage	☐	☐	☐
Pulmonary embolism	☐	☐	☐
Systemic infection	☐	☐	☐
Seizure	☐	☐	☐
Wound infection	☐	☐	☐
Adverse drug reaction	☐	☐	☐

Specify_____

Other	☐	☐	☐

Specify_____

19. Postop neurological status (following current surgery at 1-3 weeks postop)

- ☐ Worse
- ☐ Same
- ☐ Better

20. Treatment plan

	Yes	No
Systemic chemotherapy	☐	☐
External beam radiation therapy	☐	☐
Brachytherapy	☐	☐
Stereotactic radiosurgery	☐	☐
Stereotactic radiotherapy	☐	☐
Observation	☐	☐
Hospice	☐	☐
Other	☐	☐

Specify_____

21. Is the patient enrolled in a formal clinical brain tumor trial?

- ☐ Yes (Specify _____)
- ☐ No

22. **Comments (other treatments, etc)**

_____

_____

_____

_____

_____

_____

_____

_____

If this is an additional surgery (i.e. a new operation for glioma after the enrollment surgery), please answer these questions.

23. Adjuvant therapy (since last GO Project Perioperative Form completed)

	Yes	No	Unknown
Systemic chemotherapy	☐	☐	☐
External beam radiation therapy	☐	☐	☐
Brachytherapy	☐	☐	☐
Stereotactic radiosurgery	☐	☐	☐
Stereotactic radiotherapy	☐	☐	☐
Other	☐	☐	☐

Specify_____

24. Complications of therapy (since last GO Project Perioperative Form completed)

	Yes	No	Unknown	N/A
Systemic chemotherapy	☐	☐	☐	☐
External beam radiation therapy	☐	☐	☐	☐
Brachytherapy.	☐	☐	☐	☐
Stereotactic radiosurgery	☐	☐	☐	☐
Stereotactic radiotherapy	☐	☐	☐	☐
Other	☐	☐	☐	☐

Specify_____

Thank You for Completing This Questionnaire

Please return the completed form in the envelope provided. If you lose the envelope and want another, call 1-888-820-7171. Our address is

GO Project
Center for Outcomes Research
Department of Surgery
UMass Medical School
365 Plantation Street, Suite 185
Worcester, MA 01605-2379