GLIOMA OUTCOMES PROJECT

Retrospective Form - Version 1.0

This form should be completed by a physician or study coordinator for all patients who are enrolled at other than first surgery for a brain tumor. 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

Preoperative Assessment

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

2. 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_____

3. Time from initial symptoms to first surgery

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

Perioperative Summary

Please answer the questions below in relation to the time period PRIOR to enrollment surgery

4. Tumor Characteristics (at time of FIRST surgery)

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

☐ I
☐ II
☐ III
☐ IV

f. Tumor pathology

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

5. a. Date of biopsy __ __ / __ __
month / year

b. Type of biopsy

☐ Image guided biopsy
☐ Craniotomy for biopsy

6. a. Did the patient have a prior resection? *

☐ Yes
☐ No

* If yes, please answer Questions 6b, 6c, 7 and 8. Otherwise, skip to Question 9.

b. Date of resection __ __ / __ __
month / year

c. Type of resection

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

7. Was cortical mapping used?

☐ Yes
☐ No

8. Were implantable carmustine wafers used?

☐ Yes (Specify #_____)
☐ No

9. Were radioactive seeds implanted?

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

10. Postop neurological status (following FIRST surgery)

☐ Worse
☐ Same
☐ Better

11. Morbid events (PRIOR to enrollment surgery)

	Yes	No	Unknown
Depression	☐	☐	☐
Deep vein thrombosis	☐	☐	☐
Intracranial hemorrhage	☐	☐	☐
Pulmonary embolism	☐	☐	☐
Systemic infection	☐	☐	☐
Seizure	☐	☐	☐
Wound infection	☐	☐	☐
Gastrointestinal ulcer	☐	☐	☐
Hydrocephalus	☐	☐	☐
Cognitive impairment	☐	☐	☐
Steroid induced diabetes	☐	☐	☐
Steroid myopathy	☐	☐	☐
Adverse drug reaction	☐	☐	☐

Specify_____
Other ☐ ☐ ☐
Specify_____

12. Adjuvant therapy (PRIOR to enrollment surgery)

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

Specify_____

13. Complications of therapy (PRIOR to enrollment surgery)

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

Specify_____

14. Comments (other treatments, etc)

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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

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