International CPT-SIOP-Registry – Registration Form A1

PI: Dr. med. Uwe Kordes, Klinik und Poliklinik für Pädiatrische Hämatologie und Onkologie,
Universitätsklinikum Hamburg-Eppendorf, Martinistr. 52, 20246 Hamburg
Tel. (+49) 40-7410-57697, Fax: (+49) 40-7410-57544 , e-mail: cpt@uke.de, url: www.uke.de/cpt

In Cooperation with the German Childhood Cancer Registry (GCCR), at IMBEI, Universitätsmedizin Mainz, 55101 Mainz (for patients registered in Germany)
Tel.: (+49) 6131 /17-6808 , Fax: (+49) 6131 / 17-4462, url: www.kinderkrebsregister.de

Last Name, First Name |_____| Pat.Nr. |_____| Gender |__| (1=male, 2=female) Date of birth |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

MaligID *(GCCR)*: |__|__|__|__|__| Klinik *(GCCR)*: |__|__|__|__| GPOH-PID: |__|__|__|__|__|__|__|__| *(only in Germany)*

Reporting Institution (name, address): _____

Contact Fax number: _____ Contact phone number: _____

Contact person in reporting institution: _____

Please make sure that the consent form is signed before transmitting these data !

Previous therapy elsewhere: ❑ No ❑ Yes, where: _____

Reason for diagnosis:
❑ Tumor-related symptoms prompted medical evaluation
❑ Routine health care maintenance visit (e.g. U1 – U9)
❑ Incidental finding in other diagnostic testing

Positive family history (Leukemia, tumor, immune-deficiency, syndrome e.g. Li-Fraumeni, Aicardi):
❑ No
❑ Yes, parents: which:
_____
❑ Yes, siblings: which:
_____
❑ Yes, other: which: _____

Previous tumor disease:
❑ No
❑ Yes, which:
_____
Date: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Physical status at diagnosis:
❑ normal activity, no disabilities
❑ minor disability, not requiring additional assistance
❑ age-related activity greatly reduced (e.g. unable to attend kindergarten or school)
❑ bed-ridden, requiring nursing care
❑ intensive medical care, moribund

Date of Diagnosis: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Localization primary tumor:
❑ right lateral ventricle
❑ left lateral ventricle
❑ else:
❑ III. Ventricle
❑ IV. Ventricle
❑ cerebellar-pontine angle
❑ multi-focal

Are there secondary tumor locations ? : ❑ No
❑ Yes: please specify: _____

Lumbar liquor positive for tumor cells: ❑ No ❑ Yes ❑ Not available

Ventricular liquor positive for tumor cells: ❑ No ❑ Yes ❑ Not available

Liquor sent for reference review (address in consent form) ? : ❑ No ❑ Yes

Previous therapy: ❑ No
❑ Yes, which _____

Start of therapy: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Surgery date
Biopsy |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
Resection |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
Second Surgery |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Surgeon´s opinion on completeness of the most recent resection:
❑ no visible tumor left (gross total resection)
❑ minimal tumor tissue left (less than 2 mm tumorsheat)
❑ still macroscopically visible tumor present

Histology:
❑ Choroid Plexus Papilloma WHO°I ❑ Atypical Choroid Plexus Papilloma WHO°II
❑ Choroid Plexus Carcinoma WHO°III
❑ else: _____

Have the slides already been sent to the pathology reference center ? :
❑ No
❑ Yes, please fax pathology report if available

Reporting local pathologist: Number of specimen: _____ Pathologist: _____
Phone number: _____ City: _____
Institution: _____

Postoperative imaging:
CT-Date: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY
MRI-Date: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Result of postoperative imaging:
❑ no suspicion of residual tumor
❑ lesion visible, nature of lesion unclear
❑ clearly still residual tumor present: **primary lesion ?** ❑ No ❑ Yes
metastasis/secondary lesion ? ❑ No ❑ Yes

Imaging sent for reference radiology review (address in consent from)? : ❑ No ❑ Yes

Notes:

Patient expired: ❑ No ❑ Yes:

Date of death: |__|__|.|__|__|.|__|__|__|__| DD.MM.YYYY

Stamp	Date	Signature