SGO COR
Clinical Outcomes Registry

FOLLOW UP CARE AND SURVEILLANCE ENDOMETRIAL CANCER
Data Collection Form

July 2021

I. PATIENT DEMOGRAPHICS

Medical Record Number	Date of Birth	Zip Code

Race (select all applicable)				
	◯ White/Caucasian	◯ Asian	◯ Native Hawaiian/Pacific Islander	◯ Unknown
	◯ African American	◯ American Indian/Alaskan Native	◯ Hispanic/Latino/Spanish	◯ Chose Not to Disclose

Date of Service	Provider Specialty:	◯ Gynecologic Oncology	◯ Obstetrics and Gynecology	◯ Other _____

III. FOLLOW UP CARE AND SURVEILLANCE

PATIENT FOLLOW UP CARE PROVIDED ELSEWHERE ◯ Data unavailable ◯ Data provided (please complete below)	◯ Patient Declined Follow Up Care	◯ Not part of care plan
Clinical Trial Offered: ◯ Yes ◯ No ◯ Unavailable		

◯ Primary therapy	◯ Recurrence therapy Recurrence Site: ◯ Vagina ◯ Pelvic ◯ Abdominal ◯ Distant (outside abdomen)		
Chemotherapy Given: ◯ Yes ◯ No If Yes, Provide Agents	Cisplatin # Cycles _____	Carboplatin # Cycles _____	Paclitaxel # Cycles _____
	Adriamycin # Cycles _____	Bevacizumab # Cycles _____	Tamoxifen # Cycles _____
	Megace # Cycles _____	Progesterone IUD # Cycles _____	Other _____ # Cycles _____
Was a chemosensivity assay consulted during treatment: ◯ Yes ◯ No	If Yes, Chemosensitivity Patient Report Accession Number: _____	Were biomarkers consulted during treatment: ◯ Yes ◯ No	

Genetic Testing Recommended: ◯ Yes ◯ No	Genetic Testing Performed: ◯ Yes ◯ No	If Yes to genetic testing performed, indicate type of test and results: Type of Test: ◯ Breast and Ovarian ◯ Lynch Syndrome Test Result: ◯ Positive for Deleterious Mutation ◯ Negative No Mutation Detected ◯ Variant of Uncertain Significance

Radiotherapy Given: ◯ Yes ◯ No	If Yes, specify type of therapy below.	
Vaginal Brachytherapy: ◯ Yes ◯ No	If Yes, Number of Treatments	Total Dose
External Beam Radiation Pelvis: ◯ Yes ◯ No	If Yes, Number of Treatments	Total Dose
Para-aortic Radiation: ◯ Yes ◯ No	If Yes, Number of Treatments	Total Dose

IV. FOLLOW UP CARE-RELATED DEATH

Date of Death
◯ Yes ◯ No