SGO COR
Clinical Outcomes Registry

FOLLOW UP CARE AND SURVEILLANCE OVARIAN 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

II. FOLLOW UP CARE AND SURVEILLANCE

PATIENT FOLLOW UP CARE PROVIDED ELSEWHERE		
◯ Data unavailable ◯ Data provided (please complete below)	◯ Patient Declined Follow Up Care	◯ Documented Medical Reason for No Follow Up Care

◯ Primary therapy	◯ Recurrence therapy Recurrence Site: ◯ Vaginal ◯ Pelvic ◯ Abdominal ◯ Distant (outside abdomen)			
Start Date	Final Treatment Date	Total Number of Cycles		
Chemotherapy Given: ◯ Yes ◯ No (Select all drugs that apply)	◯ Cisplatin ◯ IV # Cycles _____ ◯ IP # Cycles _____ ◯ IV/IP # Cycles _____	◯ Carboplatin ◯ IV # Cycles _____ ◯ IP # Cycles _____ ◯ IV/IP # Cycles _____	◯ Docetaxel (Taxotere) ◯ IV # Cycles _____ ◯ IP # Cycles _____ ◯ IV/IP # Cycles _____	◯ Paclitaxel ◯ IV # Cycles _____ ◯ IP # Cycles _____ ◯ Dose-Dense # Cycles _____ ◯ IV/IP # Cycles _____
	◯ Etoposide ◯ IV # Cycles _____ ◯ IV/IP # Cycles _____	◯ Abraxane ◯ IV # Cycles _____ ◯ IV/IP # Cycles _____	◯ Gemcitabine ◯ IV # Cycles _____ ◯ IV/IP # Cycles _____	◯ Liposomal Doxorubicinn ◯ IV # Cycles _____ ◯ IV/IP # Cycles _____
	◯ Topotecan ◯ IV # Cycles _____ ◯ IV/IP # Cycles _____	◯ Ifosfamide ◯ IV # Cycles _____ ◯ IV/IP # Cycles _____	◯ Other ◯ IV # Cycles _____ ◯ IP # Cycles _____ ◯ Dose-Dense # Cycles _____ ◯ IV/IP # Cycles _____	
Is Patient on Clinical Trial that Does Not Offer Taxane and Platinum? ◯ Yes ◯ No				
Bevacizumab: ◯ Yes ◯ No	◯ Adjuvant ◯ Maintenance ◯ Both		Number of 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

III. FOLLOW UP CARE-RELATED DEATH

◯ Yes ◯ No	Date of Death