FORM H: SCREENING TUMOR EVALUATION

PATIENT ID#: ____ ____ ___

PATIENT INITIALS: ____ ____ ___

Center: _____

Form completed by: _____

Date of assessment: __ __/__ __/__ __ __ __

	Yes	No	NA	Results
1. Chest X-ray Date: __ __/__ __/__ __ __ __	1☐	2☐	9☐	
2. CT scan Date: __ __/__ __/__ __ __ __ _____ _____ _____	1☐	2☐	9☐	
3. MRI Date: __ __/__ __/__ __ __ __ _____ _____ _____	1☐	2☐	9☐	
4. Bone Scan Date: __ __/__ __/__ __ __ __	1☐	2☐	9☐	
5. Bone Marrow Aspiration/Biopsy Date: __ __/__ __/__ __ __ __	1☐	2☐	9☐	