Patient's baseline demographics, COVID-19 and cancer information

BRANCHING LOGIC EXISTS IN THE FIELDS BELOW WHICH IS NOT REFLECTED IN THE FORMS

Please contact CENTRA@asco.org if you have any problems with the data capture instruments

BASELINE DEMOGRAPHICS AND MEDICAL HISTORY

Patient's gender:	◯ Male ◯ Female ◯ Other ◯ Unknown
Patient's race:	◯ White ◯ Black or African-American ◯ Asian ◯ American Indian or Alaska Native ◯ Native Hawaiian or Other Pacific Islander ◯ Unknown
Patient's Ethnicity:	◯ Hispanic or Latino ◯ Non-Hispanic or Non-Latino ◯ Unknown
Do you have access to the ICD-10 code for the patient's primary cancer diagnosis? It is strongly preferred that ICD-10 codes are entered. If you need to look up an ICD-10 code, please refer to this site: https://www.icd10data.com/ICD10CM/Codes/C00-D49	◯ Yes ◯ No
Primary cancer currently being managed: Please enter relevant ICD-10 code, or begin typing cancer type to use auto-fill feature.	_____
Primary cancer currently being managed:	◯ Bladder Cancer ◯ Breast Cancer ◯ Colon and Rectal Cancer ◯ Endometrial Cancer ◯ Kidney Cancer ◯ Leukemia ◯ Liver Cancer ◯ Lung Cancer ◯ Melanoma ◯ Non-Hodgkin Lymphoma ◯ Pancreatic Cancer ◯ Prostate Cancer ◯ Thyroid Cancer ◯ Other
Other cancer type:	_____
Date of initial cancer diagnosis (for primary cancer being managed):	_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Use of tobacco products:	◯ Current smoker (including e-cigarettes and vaping) ◯ Former smoker (including e-cigarettes and vaping) ◯ Never smoked ◯ Unsure
Type of tobacco products for former or current smokers: (check all that apply)	☐ Cigarette ☐ E-cigarette or vaping ☐ Cigar ☐ Pipe ☐ Unknown
How many years ago did the patient start smoking (any type of tobacco product)?	◯ < 1 year ◯ 1 - 5 years ◯ 6 - 9 years ◯ 10 or more years ◯ Unknown
How long since the patient quit smoking?	◯ < 1 year ◯ 1 - 5 years ◯ 6 - 9 years ◯ 10 or more years ◯ Unknown
Comorbidities or healthcare conditions requiring active treatment in the past 12 months: (check all that apply)	☐ Alcoholism ☐ Chronic supplemental oxygen needed ☐ Cirrhosis ☐ Congestive heart failure (CHF) ☐ Coronary artery disease (CAD) ☐ Dementia ☐ Diabetes ☐ Hepatitis ☐ History of solid organ transplant ☐ HIV/AIDS ☐ Hypertension ☐ Immuno-suppressed due to non-cancer related treatment (defined as outpatient use of systemic corticosteroids (>=10mg/d prednisone), use of chemotherapy, use of immunosuppressive agents for solid organ transplant or for an autoimmune disease). ☐ Inflammatory bowel disease ☐ Pulmonary disease (specify pulmonary condition below) ☐ Renal (specify renal condition below) ☐ Systemic autoimmune disease ☐ Patient has NONE of the above listed comorbidities or conditions
Is the patient taking an ACE inhibitor for his/her hypertension?	◯ Yes ◯ No ◯ Unsure

Please specify pulmonary conditions: (check all that apply)	☐ Asthma ☐ COPD/Emphysema ☐ Obstructive sleep apnea ☐ History of pulmonary embolism ☐ Radiation pneumonitis ☐ Immune checkpoint inhibitor pneumonitis
Please specify renal conditions: (check all that apply)	☐ Chronic renal insufficiency (CRI/CKD) ☐ End-stage renal disease, NOT on dialysis ☐ End-stage renal disease, on dialysis
What other comorbidities or health conditions has the patient received treatment for in the previous 12 months? Please separate multiple conditions with a semicolon (;).	_____
Does the patient have a prior or concurrent malignancy?	◯ Yes ◯ No
Is the patient pregnant?	◯ Yes ◯ No
Date of clinical encounter associated with this report of the patient's COVID-19 and cancer status:	_____
	_____
The date you selected is in the future. Please revisit the date field above and revise your entry.	
Patient's height (in cm):	_____
Patient's weight (in kg):	_____
Patient's ECOG performance status at clinical encounter:	◯ 0 - Fully active, able to continue with all pre-disease activities without restriction. ◯ 1 - Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work. ◯ 2 - Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours. ◯ 3 - Capable of only limited self-care. Confined to bed or chair more than 50% of waking hours. ◯ 4 - Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair. ◯ 5 - Dead
Date of death:	_____
	_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Has the patient died since the last clinical encounter?	◯ Yes ◯ No
Cause of death:	◯ Cancer progression ◯ Complication of cancer treatment ◯ COVID-19 or complications due to COVID-19 ◯ Another cause unrelated to Cancer or COVID-19 ◯ Unknown cause of death

Although the patient has died, please complete the following information regarding the patient's COVID-19 experience.

COVID-19 INFORMATION:

Date of positive COVID-19 test:
(use best approximation if exact date is not known) _____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

What was the reason for testing the patient for COVID-19?	◯ Patient had symptoms consistent with COVID-19 ◯ Patient had exposure to a COVID-19 patient ◯ Routine to test the patient prior to anti-cancer treatment in our practice ◯ Other ◯ Unknown
Where was the SARS-CoV-2 test performed?	◯ CDC ◯ State or local health department lab ◯ Commercial lab (e.g., Quest, LabCorp) ◯ Hospital lab ◯ Other ◯ Unknown
Where was the test performed?	_____
Other reason for testing:	_____
Patient's reported likely source of exposure method:	◯ Known exposure to a person with COVID-19 ◯ Community exposure ◯ Unknown
What is the patient's current COVID-19 status?	◯ Symptomatic ◯ COVID-19 test positive but asymptomatic ◯ Fully recovered with no current symptoms ◯ Deceased due to COVID-19 or COVID-19 complication ◯ Deceased due to other or unknown cause

Given full recovery of symptoms, what is the patient's COVID-19 test status?	◯ Patient has tested negative since resolution of symptoms ◯ Patient is still COVID-19 positive despite resolution of symptoms ◯ Patient was not retested after symptom resolution (i.e., COVID-19 test status is unknown)
Date of COVID-19 symptom onset: (leave blank if patient has never had symptoms)	_____
	_____
The date you selected is in the future. Please revisit the date field above and revise your entry.	
What COVID-19 symptoms has the patient experienced? (check all that apply)	☐ Fever ☐ Headache ☐ Sore throat ☐ Cough ☐ Shortness of breath ☐ Loss of taste or smell ☐ Diarrhea ☐ Vomiting ☐ Other ☐ None of the above (Asymptomatic)
Other COVID-19 symptoms:	_____
Has the patient developed pneumonia?	◯ Yes ◯ No
Is the patient receiving any care or treatment (for COVID-19 or cancer) via telemedicine?	◯ Yes ◯ No ◯ Unsure
Has the patient been hospitalized for COVID-19 or COVID-19 complications?	◯ No ◯ Yes, but not in the intensive care unit ◯ Yes, in the intensive care unit
Has the patient been admitted to a temporary hospital, such as a field hospital or other building converted to a hospital for the COVID-19 crisis?	◯ Yes ◯ No ◯ Unknown
Date of admission to hospital:	_____
	_____
The date you selected is in the future. Please revisit the date field above and revise your entry.	
Date of admission to intensive care unit:	_____
	_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Has the patient been discharged from the intensive care unit?
- ◯ Yes
- ◯ No

Date of discharge from the ICU:

_____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Has the patient been discharged from the hospital?
- Yes
- ◯ No
- ◯

Date of discharge from hospital:

_____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

What COVID-19 treatments has the patient received?

	Yes	No	Unsure or unknown
Supplemental oxygen	◯	◯	◯
Ventilator	◯	◯	◯
Anti-COVID-19 drugs	◯	◯	◯
Other treatment approaches	◯	◯	◯

What date did the patient start supplemental oxygen?

_____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Is the patient still on supplemental oxygen?
- ◯ Yes
- ◯ No
- ◯ Unsure

When did the patient stop using supplemental oxygen (if known)?

_____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

What date did the patient start treatment with a ventilator?

_____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Is the patient still on a ventilator?

- ◯ Yes
- ◯ No
- ◯ Unsure

When did the patient stop using a ventilator?

_____

_____

The date you selected is in the future. Please revisit the date field above and revise your entry.

Which anti-COVID-19 drugs has the patient received? (check all that apply)

- ☐ ribavirin
- ☐ remdesivir
- ☐ lopinavir + ritonavir (kaletra)
- ☐ avipiravir
- ☐ hydroxychloroquine
- ☐ chloroquine
- ☐ tocilizumab
- ☐ siltuximab
- ☐ azithromycin
- ☐ losartan
- ☐ convalescent plasma
- ☐ mesenchymal stem cells
- ☐ IVIG
- ☐ Other
- ☐ Unknown

Other anti-COVID19 drugs:

_____

Has the patient experienced any of the following SYSTEMIC complications during his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Bleeding	◯	◯	◯
Disseminated intravascular coagulation	◯	◯	◯
Sepsis	◯	◯	◯

Has the patient experienced any of the following PULMONARY complications during his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
ARDS	○	○	○
Pneumonitis	○	○	○
Pulmonary embolism	○	○	○
Respiratory failure	○	○	○

Has the patient experienced any of the following CARDIOVASCULAR complications during his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Cardiac arrythmia	○	○	○
Cerebrovascular accident (e.g., CVA, stroke)	○	○	○
Congestive heart failure	○	○	○
Deep venous thrombosis	○	○	○
Myocardial infarction	○	○	○

Has the patient experienced any of the following GASTROINTESTINAL complications during his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Acute hepatic injury	○	○	○
Bowel perforation	○	○	○
Peritonitis	○	○	○

Has the patient experienced any of these OTHER complications during his/her COVID-19 illness?

	Yes	No	Unsure/Unknown
Acute renal failure	○	○	○
Encephalopathy	○	○	○
Seizures	○	○	○

COVID-19 CLINICAL TRIAL PARTICIPATION

Has the patient received treatment for COVID-19 as part of a therapeutic clinical trial?
- ○ Yes
- ○ No

PATIENT'S CANCER INFORMATION

Extent of cancer at the time of COVID-19 diagnosis:
- ○ Localized
- ○ Regional
- ○ Metastatic
- ○ Disease-free (receiving adjuvant therapy)

What type of adjuvant therapy has the patient been receiving? (check all that apply)
- ☐ Radiation therapy
- ☐ Drug-based therapy

Please specify the type of drug-based adjuvant therapies the patient was receiving at the time of COVID-19 diagnosis:
(check all that apply)

- ☐ Antibody-Drug Conjugate
- ☐ Cellular Therapy
- ☐ Cytotoxic Chemotherapy
- ☐ Hormone Therapy
- ☐ Immune Checkpoint Inhibitor
- ☐ Other Immunotherapy
- ☐ Targeted Monoclonal Antibody
- ☐ Targeted Small Molecule Therapy

What was the patient's cancer treatment status at the time ofCOVID-19 diagnosis?

- ◯ Initial diagnosis and deciding initial therapy
- ◯ In active anti-cancer therapy
- ◯ Receiving supportive care only

What type of therapies are under consideration?
(check all that apply)

- ☐ Surgery
- ☐ Radiation therapy
- ☐ Drug-based therapy
- ☐ Supportive care only

Which type of anti-cancer treatments were ongoing or planned for this patient at the time of COVID-19 diagnosis? (check all that apply)

- ☐ Surgery
- ☐ Radiation therapy
- ☐ Drug-based therapy

Please specify types of drugs under consideration:
(check all that apply)

- ☐ Antibody-Drug Conjugate
- ☐ Cellular Therapy
- ☐ Cytotoxic Chemotherapy
- ☐ Hormone Therapy
- ☐ Immune Checkpoint Inhibitor
- ☐ Other Immunotherapy
- ☐ Targeted Monoclonal Antibody
- ☐ Targeted Small Molecule Therapy

Please specify types of drugs that were ongoing or planned:
(check all that apply)

- ☐ Antibody-Drug Conjugate
- ☐ Cellular Therapy
- ☐ Cytotoxic Chemotherapy
- ☐ Hormone Therapy
- ☐ Immune Checkpoint Inhibitor
- ☐ Other Immunotherapy
- ☐ Targeted Monoclonal Antibody
- ☐ Targeted Small Molecule Therapy

Is the patient enrolled in hospice?

- ◯ Yes
- ◯ No

Is the patient enrolled on a therapeutic cancer clinical trial?

- ◯ Yes
- ◯ No

CANCER TREATMENT DELAYS AND DISCONTINUATIONS DUE TO COVID-19

Due to the patient's diagnosis with COVID-19, do you plan to delay treatment, or use a less aggressive treatment strategy with any aspect of the patient's anti-cancer treatment?

- ◯ Yes
- ◯ No
- ◯ Unsure

Which components of care would be DELAYED due to COVID-19 disease? (check all that apply)

- ☐ Surgery
- ☐ Radiation
- ☐ Drug-based
- ☐ None

Please specify types of drugs you plan to delay for this patient: (check all that apply)	☐ Antibody-Drug Conjugate ☐ Cellular Therapy ☐ Cytotoxic Chemotherapy ☐ Hormone Therapy ☐ Immune Checkpoint Inhibitor ☐ Other Immunotherapy ☐ Targeted Monoclonal Antibody ☐ Targeted Small Molecule Therapy
Which treatment modalities would you have used to treat this patient's cancer, but will not use due to the impact of COVID-19 on the patient's health or on the current availability of that treatment modality at your institution? (check all that apply)	☐ Surgery ☐ Radiation ☐ Drug-based ☐ None
Please specify which types of drugs you would you have used to treat this patient's cancer, but will not use due to the impact of COVID-19 on the patient's health or on the current availability of that treatment modality at your institution? (check all that apply)	☐ Antibody-Drug Conjugate ☐ Cellular Therapy ☐ Cytotoxic Chemotherapy ☐ Hormone Therapy ☐ Immune Checkpoint Inhibitor ☐ Other Immunotherapy ☐ Targeted Monoclonal Antibody ☐ Targeted Small Molecule Therapy
Since the patient's diagnosis with COVID-19, has the patient experienced any delays or discontinuations of cancer treatment (or are any expected in the near future)?	◯ Yes ◯ No
Which components of care have been DELAYED ? (check all that apply)	☐ Surgery ☐ Radiation ☐ Drug-based ☐ None
What is the primary reason for the delay of treatment?	◯ Progressive disease ◯ Treatment-related toxicity ◯ Patient's COVID-19 disease ◯ Lack of clinical resources due to COVID-19 crisis ◯ Patient's choice (i.e., non-clinical reason) ◯ Other
Other reason for delay:	_____
Which components of care have been DISCONTINUED? (check all that apply)	☐ Surgery ☐ Radiation ☐ Drug-based ☐ None
Which drug-based therapies have been discontinued? (check all that apply)	☐ Antibody-Drug Conjugate ☐ Cellular Therapy ☐ Cytotoxic Chemotherapy ☐ Hormone Therapy ☐ Immune Checkpoint Inhibitor ☐ Other Immunotherapy ☐ Targeted Monoclonal Antibody ☐ Targeted Small Molecule Therapy

What is the primary reason for the discontinuation of treatment?	◯ Progressive disease ◯ Treatment-related toxicity ◯ Patient's COVID-19 disease ◯ Lack of clinical resources due to COVID-19 crisis ◯ Patient's choice (i.e., non-clinical reason) ◯ Other
Other reason for discontinuation:	_____
Who made the choice to delay or discontinue therapy?	◯ Treating oncologist ◯ Patient ◯ Other (e.g., other physician)
Other person who made decision:	_____
Is the patient still on any anti-cancer therapies (despite delay or discontinuation of one or more types of anti-cancer therapies)?	◯ Yes ◯ No
What anti-cancer therapies is the patient currently receiving (or is scheduled to receive)? (check all that apply)	☐ Surgery ☐ Radiation ☐ Drug-based therapy
Please specify types of drugs to the patient is currently receiving: (check all that apply)	☐ Antibody-Drug Conjugate ☐ Cellular Therapy ☐ Cytotoxic Chemotherapy ☐ Hormone Therapy ☐ Immune Checkpoint Inhibitor ☐ Other Immunotherapy ☐ Targeted Monoclonal Antibody ☐ Targeted Small Molecule Therapy
Do you have plans to prescribe anti-cancer therapy instead of other anti-cancer treatment(s) that have been delayed or discontinued? (e.g., less toxic treatments, or drug-therapy in the event of a required surgery delay)	◯ Yes ◯ No
What types of therapies are you prescribing instead of the other anti-cancer therapies that had been planned? (check all that apply)	☐ Surgery ☐ Radiation ☐ Drug-based therapy ☐ None of the above
Please specify types of drugs to be used instead of the planned treatment approach: (check all that apply)	☐ Antibody-Drug Conjugate ☐ Cellular Therapy ☐ Cytotoxic Chemotherapy ☐ Hormone Therapy ☐ Immune Checkpoint Inhibitor ☐ Other Immunotherapy ☐ Targeted Monoclonal Antibody ☐ Targeted Small Molecule Therapy