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

**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?  
- Yes  
- No

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

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):  

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

<table>
<thead>
<tr>
<th>Use of tobacco products:</th>
<th>Current smoker (including e-cigarettes and vaping)</th>
<th>Former smoker (including e-cigarettes and vaping)</th>
<th>Never smoked</th>
<th>Unsure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of tobacco products for former or current smokers: (check all that apply)</th>
<th>Cigarette</th>
<th>E-cigarette or vaping</th>
<th>Cigar</th>
<th>Pipe</th>
<th>Unsure</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How many years ago did the patient start smoking (any type of tobacco product)?</th>
<th>&lt; 1 year</th>
<th>1 - 5 years</th>
<th>6 - 9 years</th>
<th>10 or more years</th>
<th>Unknown</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>How long since the patient quit smoking?</th>
<th>&lt; 1 year</th>
<th>1 - 5 years</th>
<th>6 - 9 years</th>
<th>10 or more years</th>
<th>Unknown</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Comorbidities or healthcare conditions requiring active treatment in the past 12 months: (check all that apply)</th>
<th>Alcoholism</th>
<th>Chronic supplemental oxygen needed</th>
<th>Cirrhosis</th>
<th>Congestive heart failure (CHF)</th>
<th>Coronary artery disease (CAD)</th>
<th>Dementia</th>
<th>Diabetes</th>
<th>Hepatitis</th>
<th>History of solid organ transplant</th>
<th>HIV/AIDS</th>
<th>Hypertension</th>
<th>Immuno-suppressed due to non-cancer related treatment (defined as outpatient use of systemic corticosteroids (&gt;=10mg/d prednisone), use of chemotherapy, use of immunosuppressive agents for solid organ transplant or for an autoimmune disease)</th>
<th>Inflammatory bowel disease</th>
<th>Pulmonary disease (specify pulmonary condition below)</th>
<th>Renal (specify renal condition below)</th>
<th>Systemic autoimmune disease</th>
<th>Patient has NONE of the above listed comorbidities or conditions</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Is the patient taking an ACE inhibitor for his/her hypertension?</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
</table>
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?

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>No</th>
<th>Unsure or unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental oxygen</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ventilator</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Anti-COVID-19 drugs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other treatment approaches</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
<th>Unsure/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disseminated intravascular coagulation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sepsis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Has the patient experienced any of the following PULMONARY complications during his/her COVID-19 illness?

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
<th>Unsure/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARDS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory failure</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
<th>Unsure/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac arrythmia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular accident (e.g., CVA, stroke)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deep venous thrombosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
<th>Unsure/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute hepatic injury</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel perforation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peritonitis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Complication</th>
<th>Yes</th>
<th>No</th>
<th>Unsure/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute renal failure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encephalopathy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please specify the type of drug-based adjuvant therapies the patient</td>
<td>Checkbox options</td>
</tr>
<tr>
<td>was receiving at the time of COVID-19 diagnosis: (check all that apply)</td>
<td></td>
</tr>
<tr>
<td>What was the patient's cancer treatment status at the time of COVID-19</td>
<td>Checkbox options: Initial diagnosis and deciding initial therapy,</td>
</tr>
<tr>
<td>diagnosis?</td>
<td>In active anti-cancer therapy, Receiving supportive care only</td>
</tr>
<tr>
<td>What type of therapies are under consideration? (check all that apply)</td>
<td>Checkbox options: Surgery, Radiation therapy, Drug-based therapy,</td>
</tr>
<tr>
<td>Which type of anti-cancer treatments were ongoing or planned for this</td>
<td>Checkbox options: Surgery, Radiation therapy, Drug-based therapy</td>
</tr>
<tr>
<td>patient at the time of COVID-19 diagnosis? (check all that apply)</td>
<td></td>
</tr>
<tr>
<td>Please specify types of drugs under consideration: (check all that</td>
<td>Checkbox options: Antibody-Drug Conjugate, Cellular Therapy, Cytotoxic</td>
</tr>
<tr>
<td>apply)</td>
<td>Chemotherapy, Hormone Therapy, Immune Checkpoint Inhibitor, Other</td>
</tr>
<tr>
<td>Please specify types of drugs that were ongoing or planned: (check all</td>
<td>Checkbox options: Antibody-Drug Conjugate, Cellular Therapy, Cytotoxic</td>
</tr>
<tr>
<td>that apply)</td>
<td>Chemotherapy, Hormone Therapy, Immune Checkpoint Inhibitor, Other</td>
</tr>
<tr>
<td>Is the patient enrolled in hospice?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>Is the patient enrolled on a therapeutic cancer clinical trial?</td>
<td>Yes, No</td>
</tr>
<tr>
<td>CANCER TREATMENT DELAYS AND DISCONTINUATIONS DUE TO COVID-19</td>
<td></td>
</tr>
<tr>
<td>Due to the patient's diagnosis with COVID-19, do you plan to delay</td>
<td>Checkbox options: Yes, No, Unsure</td>
</tr>
<tr>
<td>treatment, or use a less aggressive treatment strategy with any aspect</td>
<td></td>
</tr>
<tr>
<td>of the patient's anti-cancer treatment?</td>
<td></td>
</tr>
<tr>
<td>Which components of care would be DELAYED due to COVID-19 disease?</td>
<td>Checkbox options: Surgery, Radiation, Drug-based, None</td>
</tr>
<tr>
<td>(check all that apply)</td>
<td></td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the primary reason for the discontinuation of treatment?</td>
<td>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</td>
</tr>
<tr>
<td>Other reason for discontinuation:</td>
<td></td>
</tr>
<tr>
<td>Who made the choice to delay or discontinue therapy?</td>
<td>Treating oncologist, Patient, Other (e.g., other physician)</td>
</tr>
<tr>
<td>Other person who made decision:</td>
<td></td>
</tr>
<tr>
<td>Is the patient still on any anti-cancer therapies (despite delay or</td>
<td>Yes, No</td>
</tr>
<tr>
<td>discontinuation of one or more types of anti-cancer therapies)?</td>
<td></td>
</tr>
<tr>
<td>What anti-cancer therapies is the patient currently receiving (or is</td>
<td>Surgery, Radiation, Drug-based therapy</td>
</tr>
<tr>
<td>scheduled to receive)? (check all that apply)</td>
<td></td>
</tr>
<tr>
<td>Please specify types of drugs to the patient is currently receiving:</td>
<td>Antibody-Drug Conjugate, Cellular Therapy, Cytotoxic Chemotherapy,</td>
</tr>
<tr>
<td>(check all that apply)</td>
<td>Hormone Therapy, Immune Checkpoint Inhibitor, Other Immunotherapy,</td>
</tr>
<tr>
<td></td>
<td>Targeted Monoclonal Antibody, Targeted Small Molecule Therapy</td>
</tr>
<tr>
<td>Do you have plans to prescribe anti-cancer therapy instead of other</td>
<td>Yes, No</td>
</tr>
<tr>
<td>anti-cancer treatment(s) that have been delayed or discontinued? (e.g.,</td>
<td></td>
</tr>
<tr>
<td>less toxic treatments, or drug-therapy in the event of a required</td>
<td></td>
</tr>
<tr>
<td>surgery delay)</td>
<td></td>
</tr>
<tr>
<td>What types of therapies are you prescribing instead of the other</td>
<td>Surgery, Radiation, Drug-based therapy, None of the above</td>
</tr>
<tr>
<td>anti-cancer therapies that had been planned? (check all that apply)</td>
<td></td>
</tr>
<tr>
<td>Please specify types of drugs to be used instead of the planned</td>
<td>Antibody-Drug Conjugate, Cellular Therapy, Cytotoxic Chemotherapy,</td>
</tr>
<tr>
<td>treatment approach: (check all that apply)</td>
<td>Hormone Therapy, Immune Checkpoint Inhibitor, Other Immunotherapy,</td>
</tr>
<tr>
<td></td>
<td>Targeted Monoclonal Antibody, Targeted Small Molecule Therapy</td>
</tr>
</tbody>
</table>