

# Patient's baseline demographics, COVID-19 and cancer information Page 1

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?

- 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-fillfeature.

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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:

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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.

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Use of tobacco products:

- Current smoker (including e-cigarettes and vaping)
- Former smoker (including e-cigarettes and vaping)
- Never smoked
- Unsure

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Type of tobacco products for former or current smokers: (check all that apply)

- Cigarette
- E-cigarette or vaping
- Cigar
- Pipe
- Unknown

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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

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How long since the patient quit smoking?

- < 1 year
- 1 - 5 years
- 6 - 9 years
- 10 or more years
- Unknown

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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 ( $\geq 10$ mg/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

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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:

\_\_\_\_\_

\_\_\_\_\_

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

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Has the patient died since the last clinical encounter?  Yes  
 No

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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

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

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### COVID-19 INFORMATION:

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

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

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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

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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

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Where was the test performed? \_\_\_\_\_

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Other reason for testing: \_\_\_\_\_

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Patient's reported likely source of exposure method:  Known exposure to a person with COVID-19  
 Community exposure  
 Unknown

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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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ventilator	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Anti-COVID-19 drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other treatment approaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Disseminated intravascular coagulation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sepsis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Yes	No	Unsure/Unknown
ARDS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pneumonitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pulmonary embolism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respiratory failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Yes	No	Unsure/Unknown
Cardiac arrhythmia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cerebrovascular accident (e.g., CVA, stroke)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Congestive heart failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Deep venous thrombosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Myocardial infarction	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Yes	No	Unsure/Unknown
Acute hepatic injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bowel perforation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Peritonitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	Yes	No	Unsure/Unknown
Acute renal failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Encephalopathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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 of COVID-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