

Case #:

Institution #:
Form E 1

Eligibility Check List

Inclusion Criteria:

(Answer must be Yes)

- | | <u>No</u> | <u>Yes</u> |
|--|-----------------------|-----------------------|
| 1. Received radiation therapy (2005 thru 2007) | <input type="radio"/> | <input type="radio"/> |
| 2. Carcinoma of the cervix only | <input type="radio"/> | <input type="radio"/> |

Exclusion Criteria:

(Answer must be No)

- | | | |
|--|-----------------------|-----------------------|
| 3. Prior pelvic RT | <input type="radio"/> | <input type="radio"/> |
| 4. Distant metastases | <input type="radio"/> | <input type="radio"/> |
| 5. Prior or concurrent malignancies
(except non-melanoma skin cancer) | <input type="radio"/> | <input type="radio"/> |
| 6. Prior hysterectomy
(include patients with adjuvant hysterectomy) | <input type="radio"/> | <input type="radio"/> |

- | | | |
|--|-----------------------|-----------------------|
| 9. Patient eligible, according to check list | <input type="radio"/> | <input type="radio"/> |
| | No | Yes |

- | | | |
|---|-----------------------|-----------------------|
| 10. Is patient administratively ineligible? | <input type="radio"/> | <input type="radio"/> |
| | No | Yes |

11. If yes, give reason for administrative ineligibility: _____
(for example, chart unavailable)

12. Type of Radiation Therapy chart:
- | | | |
|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Electronic | Paper | Electronic and Paper |

Note: DO NOT include any Personal Health Information (PHI) in these comments.

13. Comments: _____

14. Comments: _____

15. Date of data collection (mm/dd/yyyy): ____/____/____