HOVON 900 DLBCL screening CASE REPORT FORMS

VERSION OF FORMS

Version date	**Changed form**	**Description**
09-JUN-2015	-	Version 01
10-JUL-2015	Registration form	Version 02

HOVON 900 DLBCL SCREENING

REGISTRATION FORM (1)

Instructions: Please complete this form before registration to check eligibility. Register via Internet through TOP or send this form by fax or report by telephone to HOVON Data Center. Fax +31.10.7041028. Tel +31.10.7041560
Any mistake in patient characteristics or eligibility as given at registration must be reported by sending the revised form to:
HOVON Data Center, Erasmus MC – Clinical Trial Center, P.O.Box 2040, 3000 CA ROTTERDAM, The Netherlands.

Hospital: …………………………………………… Patient study number: |___|___|___|

Hospital		8	………………………………………………
Caller (who registers the patient)		9	………………………………………………
Responsible physician		10	………………………………………………

GENERAL PATIENT DATA

Date of birth (if allowed, if not fill out 11-11-1911)		11	|____||____||________|
Sex		12	|___| 1=male 2=female
Year of birth (fill out 9999 if date of birth is filled out))		15	|________|
Date written informed consent	[dd/mm/yyyy]	16	|____||____||________|
Pathology number		17	|________| / |_____________|
Pathology laboratory where biopsy material is stored		18	………………………………………………

PATIENT GIVES CONSENT FOR

Registration of coded data in a national database for patients with DLBCL and BCL-U		19	|___| 0=no 1=yes
Use of residual body material		20	|___| 0=no 1=yes

ELIGIBILITY (see protocol paragraph 8)

Date of diagnosis	[dd/mm/yyyy]	21	|____||____||________|
PA diagnosis		22	|___| 1=DLBCL 2=BCL-U
Age at date of inclusion		24	|___|___|___|

DATA FROM HOVON DATA CENTER

Date of registration	[dd/mm/yyyy]	13	|____||____||________|
Patient study number		1	|___|___|___|___|

COMMENTS…………………………………………………………………………………………