Lung Project Data Elements

DEMOGRAPHICS	
Data Elements	**Options**
1. Provider	• First/Last
2. Date of initial Radiation/Oncology consult	• mm/dd/yyyy
3. Date of Birth	• mm/yyyy
4. Gender	• Male/Female
5. Race	• American Indian/Alaska Native • Asian • Native Hawaiian or Other Pacific Islander • Black or African American • White • Arab/Middle Eastern • Unknown or not reported • Other (free text)
6. Medical Insurance *(Check all that apply)*	• No insurance/self-pay • Medicare(all) • Medicare Advantage-BCN • Medicare Advantage- BCBSM • Medicaid-Straight • Medicaid -HMO • Other Payer (government) • Other Payer (Michigan and outstate) • BCBSM-Michigan • BCN- Michigan • Commercial-HMO
7. Current Marital Status	• Married/ Domestic Partner • Divorced • Never Married • Separated • Widowed • Living with someone • Single
8. Cancer Type	• Breast Cancer • Lung Cancer

LUNG PROJECT

L1: Patient: Pre-Treatment Lung Cancer Questionnaire

Time points: Pre RT Evaluation

Data Elements	Options
I have lack of energy	• Not at all • A little bit • Somewhat • Quite a bit • Very much
I have nausea	
Because of my physical condition, I have trouble meeting the needs of my family	
I have pain	
I am bothered by side effects of treatment	
I feel ill	
I am forced to spend time in bed	
I am able to work	
My work (include work at home) is fulfilling	
I am able to enjoy life	
I have accepted my illness	
I am sleeping well	
I am enjoying the things I usually do for fun	
I am content with the quality of my life right now	
I have been short of breath	
I am losing weight	
My thinking is clear	
I have been coughing	

I am bothered by hair loss	
I have a good appetite	
I feel tightness in my chest	
Breathing is easy for me	
Have you ever smoked	No_____ Yes_____
If Yes: I regret my smoking	Not at all A little bit Somewhat Quite a bit Very Much
Are you currently vaping?	• YES/NO
a) If yes, please select how often you change cartridges	• Cartridge refill lasts 2 days or longer • 1 Cartridge refill per day • 2 or more cartridge refills per day
b) Do you fill your own cartridge's or purchase prepackaged cartridges?	• Fill own cartridges • Purchase prepackaged cartridges
c) Do you use flavored cartridges?	• YES/NO
d) Do you use any of the following while vaping?	• Marijuana • Tobacco • THC oil • CBD with vaping

Have you ever, even once, used Cannabis?	• Prefer not to answer – Proceed to question 28 • No – Proceed to question 28 • Yes
Think specifically about the past 30 days up to and including today. What is your best estimate of the number of days you used Cannabis during the past 30 days?	• 0 days • 1 or 2 days • 3 to 5 days • 6 to 9 days • 10 to 19 days • 20 to 29 days • All 30 days
During the past 30 days, which one of the following ways did you use cannabis most often? Did you usually:	• Smoke it (for example, in a joint, bong, pipe, or blunt) • Eat it (for example, in brownies, cakes, cookies, or candy) • Drink it (for example, in tea, cola, or alcohol) • Vaporize it (for example, in an e-cigarette-like vaporizer or another vaporizing device) • Dab it (for example, using waxes or concentrates) • Apply to skin (for example, using lotions or oils) • Administer rectally (for example, using suppositories). • Use it some other way (please specify:
What is the major active ingredient in the cannabis product that you use the most? (This information can often be found on the package label.)	• THC –also called tetrahydrocannabinol • CBD –also called cannabidiol • Balanced levels of THC and CBD • I don't know • Other: _____
Please select the one response that best describes your swallowing ability over the course of the past week:	• No problems with swallowing this week • Mild soreness only • Can swallow solids with some difficulty • Cannot swallow solids • Cannot swallow liquids
Which best describes your race/ethnicity *(mark all that apply)?*	• American Indian/Alaska Native • Arab/Middle Eastern • Asian • Black or African American • Native Hawaiian or Pacific Islander • White • Other. Specify: _____

Are you of Hispanic/Latino origin?	• YES/NO
What is the highest level of education you have completed?	• Grade School or less • Some High School • High School Graduate or GED • Some College or Technical School • Associate's Degree • College Graduate (Bachelor's Degree) • Graduate Degree

For the following additional symptoms or problems, please circle or mark the number that best applies to you during the past week.

How much did you cough?	• Not at all • A little bit • Quite a bit • Very much
Did you cough up blood?	
Were you short of breath when you rested?	
Were you short of breath when you walked?	
Were you short of breath when you climbed stairs?	
Did you take any medicine for pain?	No_____ Yes_____
If yes, how much did it help?	Not at all A little bit Quite a bit Very much
What is your height?	_____ft _____in
What is your current weight?	_____ pounds.

L2: Patient: Weekly Lung Cancer Swallowing Assessment

Time points: Weekly On-Treatment Visits

Data Elements	**Options**
Please select the one response that best describes your swallowing ability over the course of the past week:	• No problems with swallowing this week • Mild soreness only • Can swallow solids with some difficulty • Cannot swallow solids • Cannot swallow liquids

L3: Patient Lung End of Treatment and Follow-up	
Time points: Last week of treatment & Follow-up visits 1-3-6 months	
Data Elements	**Options**
I have lack of energy	• Not at all • A little bit • Somewhat • Quite a bit • Very much
I have nausea	
Because of my physical condition, I have trouble meeting the needs of my family	
I have pain	
I am bothered by side effects of treatment	
I feel ill	
I am forced to spend time in bed	
I am able to work	
My work (include work at home) is fulfilling	
I am able to enjoy life	
I have accepted my illness	
I am sleeping well	
I am enjoying the things I usually do for fun	
I am content with the quality of my life right now	
I have been short of breath	• Not at all • A little bit • Somewhat • Quite a bit • Very much
I am losing weight	
My thinking is clear	
I have been coughing	
I am bothered by hair loss	
I have a good appetite	
I feel tightness in my chest	

Breathing is easy for me	
Have you ever smoked	No_____ Yes_____
If Yes: I regret my smoking	Not at all A little bit Somewhat Quite a bit Very Much
Are you currently vaping? a) If yes, please select how often you change cartridges b) Do you fill your own cartridge's or purchase prepackaged cartridges? c) Do you use flavored cartridges? d) Do you use any of the following while vaping?	• YES/NO • Cartridge refill lasts 2 days or longer • 1 Cartridge refill per day • 2 or more cartridge refills per day • Fill own cartridges • Purchase prepackaged cartridges • YES/NO • Marijuana • Tobacco • THC oil • CBD with vaping
Have any of your radiation oncology providers ever asked if you use cannabis? If the only mention of cannabis that you recall is from a survey form, then the answer is "No".	• YES/NO
Have you been satisfied with your radiation oncology providers' ability to answer questions about cannabis?	• I have not asked any questions about cannabis • No • Yes
Have you used cannabis, even once, since the first treatment in your course of radiation?	• Prefer not to answer • No • Yes

If you use cannabis, please check ALL the reason(s) that you have chosen to do so.	• For pain • For nausea • For anxiety • For depression • For poor appetite • For trouble sleeping • For the high (recreational) • To fight Cancer • Other: _____
Please select the one response that best describes your swallowing ability over the course of the past week (Select only one)	• No problems with swallowing this week • Mild soreness only • Can swallow solids with some difficulty • Cannot swallow solids • Cannot swallow liquids

For the following additional symptoms or problems, please circle or mark the number that best applies to you during the past week.

How much did you cough?	• Not at all • A little bit • Quite a bit • Very much
Did you cough up blood?	
Were you short of breath when you rested?	
Were you short of breath when you walked?	
Were you short of breath when you climbed stairs?	
Did you take any medicine for pain?	No_____ Yes_____
If yes, how much did it help?	Not at all A little bit Quite a bit Very much

L4 CDA: Lung Cancer Baseline Clinical Data	
	Time points: Pre RT Evaluation
Data Elements	**Options**
Weight (specify lbs. or kg):	_____ lb/kg.
BMI _____ or Height (specify inches or cm):	_____ BMI and_____ inches/cm.
Tumor Stage:	T_____ N_____ M_____

Histology:	• NSCLC – Squamous cell carcinoma
	• NSCLC -- Adenocarcinoma
	• SCLC –
	  ○ limited
	  ○ extensive
	  ○ Other (specify):
	• No biopsy

Tumor location: *(Check all that apply)*	• Right upper lobe • Right middle lobe • Right lower lobe • Left upper lobe • Left lower lobe • Superior sulcus
Surgical resection prior to radiation?	• YES/NO • Date: _____
Margin status	• Positive • Negative • N/A

MICHIGAN RADIATION ONCOLOGY QUALITY CONSORTIUM

MROQC Lung Data Elements Guide

Has there ever been any previous lung surgery?	• YES/ NO Date: _____ • Lobectomy • Pneumonectomy • Wedge resection • Other (specify): _____
Was Is the patient on O2 prior to radiation? When is O2 used?	• NO/YES • How many liters? _____ • Always • Daytime • Nighttime • When short of breath
Pulmonary function prior to RT:	• PFT not done_____ • FEV1_____ Liters, _____% predicted • DLCO not done_____ • DLCO_____%/mm, _____% predicted
Current smoker?	• YES • NO • Unknown
Former smoker? (quit at least one month prior to diagnosis)	• YES • NO • Unknown

Was this patient counseled by a doctor or other healthcare worker about quitting cigarettes? (applies to current smokers only)	• YES • NO

Comorbidities:

Does the patient have:	YES	NO	Does the patient have:	YES	NO
Hypertension?	❑	❑	Hemiplegia?	❑	❑
Diabetes mellitus?	❑	❑	Leukemia?	❑	❑
Scleroderma?	❑	❑	Malignant lymphoma?	❑	❑
Rheumatoid arthritis?	❑	❑	Myocardial infarction?	❑	❑
Lupus?	❑	❑	Peripheral vascular disease?	❑	❑
Cerebrovascular disease?	❑	❑	Ulcer disease?	❑	❑
Chronic pulmonary disease?	❑	❑	Liver disease?	❑	❑
Congestive heart failure?	❑	❑	Renal disease?	❑	❑
Connective tissue disease?	❑	❑	Malignant solid tumor (other than lung)?	❑	❑
Confusion?	❑	❑	Arrhythmia?	❑	❑

L5 CDA: Lung Systemic Therapy Data	
	Time points: Last Week of RT
Data Elements	**Options**
Did the patient receive systemic therapy?	• YES • NO
If yes, check all that apply:	
Before radiation therapy ❖ Prior to Surgery	Agents (check all that apply): • Cisplatin/Platinol-AQ/Platinol • Etoposide/Eposin/VePesid/VP-16 • Paclitaxel/Taxol/TAX • Carboplatin/Paraplatin/Paraplatin-AQ • Pemetrexed/Alimta • Docetaxel/Taxotere/TXT • Gemcitabine/Gemzar • Vinorelbine/Navelbine • Other (specify) _____
During radiation therapy ❖ Prior to Surgery ❖ After surgery ❖ Without planned surgery	Agents (check all that apply): • Cisplatin/Platinol-AQ/Platinol • Etoposide/Eposin/VePesid/VP-16 • Paclitaxel/Taxol/TAX • Carboplatin/Paraplatin/Paraplatin-AQ • Pemetrexed/Alimta • Docetaxel/Taxotere/TXT • Gemcitabine/Gemzar • Vinorelbine/Navelbine • Other (specify) _____
Immunotherapy before radiation therapy ❖ Prior to Surgery	Agents (check all that apply): Atezolizumab Durvalumab Nivolumab Pembrolizumab Other (specify) _____

Immunotherapy during radiation therapy ❖ Prior to Surgery ❖ After surgery ❖ Without planned surgery	Agents (check all that apply): • Atezolizumab • Durvalumab • Nivolumab • Pembrolizumab • Other (specify) _____

L6 Physician: Lung Baseline-1st Week

Time points: 1st Week of RT

Data Elements	Options
What was the date of the first fraction?	_____(mm/dd/yyyy) completed by the CDA

Baseline Toxicity Scoring (CTCAE v 4.0) Please circle **one** number in each row.

Adverse Event	0	1	2	3	4	5
Gastrointestinal disorders						
Esophagitis	none	Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; altered eating/swallowing; oral supplements indicated	Severely altered eating/swallowing; tube feeding, TPN or hospitalization indicated	Life-threatening consequences; urgent intervention indicated	Death
Esophageal Pain	none	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
General disorders						
Fatigue	none	Fatigue relieved by rest	Fatigue not relieved by rest; limiting instrumental ADL	Fatigue not relieved by rest, limiting self-care ADL		
Respiratory, thoracic and mediastinal disorders						
Cough	none	Mild symptoms; nonprescription intervention indicated	Moderate symptoms, medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL		
Dyspnea	none	Shortness of breath with moderate exertion	Shortness of breath with minimal exertion; limiting instrumental ADL	Shortness of breath at rest; limiting self-care ADL	Life-threatening consequences; urgent intervention indicated	Death
Pleuritic pain	none	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
Pneumonitis	none	Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL; oxygen indicated	Life-threatening respiratory compromise; urgent intervention indicated (e.g., tracheotomy or intubation)	Death
ECOG Performance Status[3]						

	Fully active	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	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair	Dead

What % weight loss did the patient experience over the 6 months prior to the initiation of lung cancer treatment: *(Enter "0" if patient's weight remained static, or if patient gained weight.)*	_____%
Is this patient enrolled on any lung cancer treatment clinical trial, study, or protocol (do not include MROQC)?	• YES • NO
Does this study (these studies) influence your radiation dose / treatment plan for this patient	• YES • NO • Not applicable/not on study
Does this study (these studies) influence your choice or sequencing of systemic therapy (immunotherapy and/or chemotherapy)?	• YES • NO • Not applicable/not on study
Is this a hypofractionated course of treatment (≤20 fractions inclusive of SBRT)?	• YES • NO
If yes, answer questions: Was this a pathologically confirmed cancer or clinical diagnosis?	• pathologic • clinical diagnosis
Was nodal staging performed?	• YES • NO

a) If yes, how was it determined (check all that apply)?	• Clinically by PET • Pathologically by EBUS/bronchoscopy • Pathologically by Mediastinoscopy • Other (specify): _____
Is this a peripheral, central or ultra-central lesion?	• Peripheral • Central • Ultra-central

L7 Physician: Lung Weekly

Time points: Weekly On-Treatment Visits

Data Elements	**Options**					
Toxicity Scoring (CTCAE v 4.0) Please circle **one** number in each row.						
Adverse Event	0	1	2	3	4	5
Gastrointestinal disorders						
Esophagitis	None	Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; altered eating/ swallowing; oral supplements indicated	Severely altered eating/swallowing; tube feeding, TPN or hospitalization indicated	Life-threatening consequences; urgent intervention indicated	Death
Esophageal Pain	None	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
General Disorders						
Fatigue	None	Fatigue relieved by rest	Fatigue not relieved by rest; limiting instrumental ADL	Fatigue not relieved by rest; limiting self-care ADL		
Respiratory disorders						
Cough	None	Mild symptoms; nonprescription intervention indicated	Moderate symptoms, medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL		
ECOG Performance Status*						

	Fully active	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	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair	Dead

L8 Physician: Lung Cancer Clinical Outcomes Assessment

Time points: Last week of RT

Data Elements	Options
What was the date of the last fraction?	_____(mm/dd/yyyy) completed by the CDA
Weight	_____(specify lbs. or kg)
Did any break in treatment occur? If Yes, was it due to toxicity? Was the toxicity-related treatment break >5 days?	• YES/ NO • YES/NO • YES/NO
Rate current esophageal pain on a scale of 0-10:	_____ (0-10)

Please select what you have recommended to the patient in the past month to manage esophagitis:	• None • Non-narcotic prescription medications (e.g. Magic mouthwash, Miles mixture, xylocaine) • Narcotic prescription medications (e.g. Vicodin, Percocet, morphine, oxycodone, fentanyl) • Other intervention (specify):_____
Has the patient been admitted for a cardiac event? a) If YES, date of admission: b) Select the cardiac event related to admission	• YES/NO _____(date) • Arrhythmia • Congestive Heart failure • Pericardial Effusion • Myocardial Infarction

Toxicity Scoring (CTCAE v 4.0). Please circle **one** number in each row.

Adverse Event	0	1	2	3	4	5
Gastrointestinal disorders						
Esophagitis	none	Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; altered eating/swallowing; oral supplements indicated	Severely altered eating/swallowing; tube feeding, TPN or hospitalization indicated	Life-threatening consequences; urgent intervention indicated	Death
Esophageal Pain	none	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
General Disorders						
Fatigue	none	Fatigue relieved by rest	Fatigue not relieved by rest; limiting instrumental ADL	Fatigue not relieved by rest, limiting self-care ADL		
Respiratory, thoracic and mediastinal disorders						
Cough	none	Mild symptoms; nonprescription intervention indicated	Moderate symptoms, medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL		
Dyspnea	none	Shortness of breath with moderate exertion	Shortness of breath with minimal exertion; limiting instrumental ADL	Shortness of breath at rest; limiting self-care ADL	Life-threatening consequences; urgent intervention indicated	Death

Pleuritic pain	none	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
Pneumonitis	none	Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL; oxygen indicated	Life-threatening respiratory compromise; urgent intervention indicated (e.g., tracheotomy or intubation)	Death
ECOG Performance Status*						
	Fully active	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours	Completely disabled. Cannot carry on self-care. Totally confined to bed or chair	Dead

L9 Physician: Lung Clinical Outcomes Follow up

Time points: Follow-up visits 1-3-6 months

Data Elements	Options
Weight	_____(specify lbs. or kg)
Rate current esophageal pain on a scale of 0-10:	_____ (0-10)
Please select what you have recommended to the patient in the past month to manage esophagitis:	• None • Non-narcotic prescription medications (e.g. Magic mouthwash, Miles mixture, xylocaine) • Narcotic prescription medications (e.g. Vicodin, Percocet, morphine, oxycodone, fentanyl) • Other intervention (specify):_____

Was surgical resection of the primary tumor performed after radiotherapy? a) If YES, date performed: b) If YES, what was the surgical margin status?	• YES/NO _____(date) • Positive • Negative
Disease status*: (check one*	• No evidence of disease • No evidence of progression of disease • Local/Regional progression • Distant progression • Both (Local & Distant progression)
Has the patient been admitted for a cardiac event? a) If YES, date of admission: b) Select the cardiac event related to admission	• YES/NO _____ (date) • Arrhythmia • Congestive Heart failure • Pericardial Effusion • Myocardial Infarction

Toxicity Scoring (CTCAE v 4.0). Please circle **one** number in each row.

Adverse Event	0	1	2	3	4	5
Gastrointestinal disorders						
Esophagitis	none	Asymptomatic; clinical or diagnostic observations only;	Symptomatic; altered eating/swallowing; oral supplements indicated	Severely altered eating/swallowing; tube feeding, TPN or	Life-threatening consequences; urgent intervention indicated	Death

		intervention not indicated		hospitalization indicated		
Esophageal Pain	none	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
General Disorders						
Fatigue	none	Fatigue relieved by rest	Fatigue not relieved by rest; limiting instrumental ADL	Fatigue not relieved by rest, limiting self-care ADL		
Respiratory, thoracic and mediastinal disorders						
Cough	none	Mild symptoms; nonprescription intervention indicated	Moderate symptoms, medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL		
Dyspnea	none	Shortness of breath with moderate exertion	Shortness of breath with minimal exertion; limiting instrumental ADL	Shortness of breath at rest; limiting self-care ADL	Life-threatening consequences; urgent intervention indicated	Death
Pleuritic pain	none	Mild pain	Moderate pain; limiting instrumental ADL	Severe pain; limiting self-care ADL		
Pneumonitis	none	Asymptomatic; clinical or diagnostic observations only; intervention not indicated	Symptomatic; medical intervention indicated; limiting instrumental ADL	Severe symptoms; limiting self-care ADL; oxygen indicated	Life-threatening respiratory compromise; urgent intervention indicated (e.g., tracheotomy or intubation)	Death
ECOG Performance Status*						
	Fully active	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	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours	Completely disabled. Cannot carry on self-care. Totally confined to bed or chair	Dead

L10 Physician: Lung Clinical Outcomes Follow up

Time points: Follow-up visits 1-3-6 months

Data Elements	Options
Did the patient receive systemic therapy after receiving radiation therapy?	• YES • NO
If yes, check all that apply:	

Chemotherapy	Agents (check all that apply): • Cisplatin/Platinol-AQ/Platinol • Etoposide/Eposin/VePesid/VP-16 • Paclitaxel/Taxol/TAX • Carboplatin/Paraplatin/Paraplatin-AQ • Pemetrexed/Alimta • Docetaxel/Taxotere/TXT • Gemcitabine/Gemzar • Vinorelbine/Navelbine • Other (specify) _____
Immunotherapy	Agents (check all that apply): • Atezolizumab • Durvalumab • Nivolumab • Pembrolizumab • Other (specify) _____

L11 Lung: Annual Clinical Outcomes

Time points: Annually

Data Elements	Options
Since the end of treatment, has the patient been admitted for a cardiac event?	• YES/NO
If YES, date of admission 1	_____ (date)
Select the cardiac event related to admission 1:	• Arrhythmia • Congestive Heart failure • Pericardial Effusion • Myocardial Infarction • None of the above

Since the end of treatment, has the patient been admitted for a cardiac event?	• YES/NO
If YES, date of admission 2	_____ (date)
Select the cardiac event related to admission 2:	• Arrhythmia • Congestive Heart failure • Pericardial Effusion • Myocardial Infarction • None of the above
Since the end of treatment, has the patient been admitted for a lung event?	• YES/NO
If YES, date of admission 1	_____ (date)
Select the lung event related to admission 1	• Chronic obstructive pulmonary disease-exacerbation • Pneumonia • Pneumonitis • None of the above

Since the end of treatment, has the patient been admitted for a lung event?	• YES/NO
If YES, date of admission 2	_____(date)
Select the lung event related to admission 2	• Chronic obstructive pulmonary disease-exacerbation • Pneumonia • Pneumonitis • None of the above
Disease status*: (check one*	• No evidence of disease • No evidence of progression of disease • Local/Regional progression • Distant progression • Both (Local & Distant progression)
Has the patient received any thoracic RT after their initial treatment?	• YES/NO

Has the patient tested positive for COVID-19?	• YES/NO
If YES, date of positive diagnosis:	• _____ (date) • Date not available
If YES, was the patient:	• Symptomatic • Asymptomatic • Not documented

SE2 CDA: Early Termination of MROQC Patient Participation Form

Data Elements	Options
Date of Early Termination:	_____If the patient died this would be the date of death otherwise it is the last eval. date the patient had
Reason patient is no longer being followed /participating in MROQC:	• Moved • To continue treatment elsewhere • Deceased • Hospice • Metastatic disease • Patient chose to stop treatment • Patient not returning to RT department for follow up • Medical issues (i.e. CVA, MI) prevent further participation • Lung only- annual documentation not available

LUNG Radiotherapy Technical Details Form

Data Elements	Options
Simulation Which lung has the primary tumor?	• Right • Left
Was intravenous contrast used for the patient's treatment planning simulation?	• Yes • No
Select the primary method used to assess the motion of the tumor and organs-at-risk during simulation.	• DCT • Fluoroscopy • Slow CT • Motion not assessed • Scans at multiple breath hold states • Other. Please specify: _____
Targets Which modalities were used for target delineation? Only choose datasets which were registered and fused to the treatment planning scan. Check all that apply.	• CT • Diagnostic CT • PET • MRI
How was motion accounted for during the treatment of this patient?	• ITV approach: no motion control technique was applied, but the target volumes were designed to account for breathing motion (using 4DCT, scans at multiple breath hold states, slow CT, etc.) • Voluntary breath hold without a device • Breath hold with a device (ABC, SDX, etc.) • Gating of radiotherapy (RPM, AlignRT, etc.) • Abdominal compression • Motion was not taken into account while designing volumes or by a motion management technique • Other. Please specify: _____

What was the reason for not considering motion in accordance with the MROQC target delineation guidelines?	• DCT is not available at treating institution • Use of slow CT was not feasible, due to time constraints or experience with technique • Other. Please specify: _____
Was patient specific reproducibility testing performed to ensure the breath hold position was reliable? [If " Voluntary breath hold without a device" or "Breath hold with a device (ABC, SDX, etc.)" or "Abdominal compression"]	• Yes • No
Was motion considered in the delineation of target volumes? [If "Other. Please specify:"]	• Yes • No
Was a motion encompassing GTV (IGTV) structure contoured?	• Yes • No
Select the name of the GTV structure:	• Drop-down menu: GTV, GTVp, IGTV, Other. Please specify: _____
Was a CTV or ICTV structure contoured?	• Yes • No
Enter the volume of the IGTV (GTV) in cc:	_____ cc
Enter the reason(s):	• Institutional practice • Physician preference • Ambiguity in imaging/could not define • Other. Please specify: _____
Was a motion encompassing CTV or ICTV structure defined/contoured?	• Yes • No

Select the name of the CTV structure:	• Drop-down menu: CTV, CTVp, CTV_High, ICTV, Other. Please specify: _____
Enter the volume of the ICTV (CTV) in cc	_____ cc
What is the approximate margin between the IGTV (GTV)structure and ICTV (CTV) structure in cm?	_____ cm
Enter the reason(s):	• Institutional practice • Physician preference • Ambiguity in imaging/could not define • Other. Please specify: _____
Was a PTV structure defined?	• Yes • No
Select the name of the PTV structure:	➢ Drop-down menu: PTV, PTVp, PTV_High, Other. Please specify: _____
Enter the volume of the PTV in cc	_____ cc
What is the approximate margin between the CTV structure (or GTV structure if CTV structure was not defined) and PTV structure in cm?	_____ cm
Enter the reason(s):	➢ Institutional practice ➢ Physician preference ➢ Ambiguity in imaging/could not define ➢ Other. Please specify: _____

Treatment Planning	
Do any of these structures overlap with a 2 cm expansion of the PTV? Check all that apply.	• Spinal cord • Brachial plexus • Heart • Other structure of interest. Please specify: _____ • Esophagus • No, the PTV is greater than 2 cm from all other structures
Select the number of plans treated	• drop-down menu: 1-10
For each plan, specify:	
➢ a. Planning type	• Forward planning • Inverse planning
➢ b) Dose delivered with this plan (Gy	• between 1 and 90
➢ c) Number of fractions delivered with this plan	• between 1 and 40
➢ d. Was the patient treated BID?	• Yes • No
➢ e. Treatment region	• Primary target • Primary target & nodes • Nodes

➢ Reason for plan	• Initial • Planned Boost • Planned Adaptation • Unplanned Modification
➢ f) If not initial, what was the reason?	• Minimize dose to critical structures (e.g. off-cord or off brachial plexus boost) • Patient anatomy change (e.g. lung inflation, pleural effusion change) • Change in motion management strategy • Other. Please specify: _____
➢ g. Was this plan considered SBRT?	• Yes • No
➢ h) Did this plan include a concomitant boost?	• Yes • No
➢ j) If no, enter planned dose:	_____ Gy (between 1 and 90)
➢ k) If no, enter planned number of fractions:	_____ Gy (between 1 and 40)
Treatment Delivery and Image Guidance What type of imaging was used to verify this patient's setup?	• kV/MV portal • CT (CBCT or TomoTherapy CT) • Films • Video-based system • Other. Please specify: _____

For each imaging type, specify how often the patient was imaged during treatment.	• Daily • Less than daily but more than weekly • Weekly • Other. Please specify: _____