Prostate Project Data Elements

DEMOGRAPHICS

Data Elements	Options
1. Exclude	• Yes/No
a. If the patient is excluded, select the reason why	• Patient had prior pelvic radiation • Patient had focal therapy (cryotherapy, HIFU, or focal laser ablation) • Neuroendocrine or small cell prostate cancer confirmed by pathology • Patient refused to complete surveys • Patient does not have email • Metastatic Disease • Other:Pleasespecify
2. Provider	• First/Last
3. Date of initial Radiation/Oncology consult	• mm/dd/yyyy
4. Date of Birth	• mm/dd/yyyy
5. Zip Code	_____
6. Race *(Select only one)*	• 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)
7. 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
8. Current Marital Status	• Married/ Domestic Partner • Divorced • Never Married • Separated • Widowed • Living with someone • Single
9. Prostate Status:	• Intact Prostate Biopsy Date (mm/dd/yyyy): _____ • Post Prostatectomy Surgery date (mm/dd/yyyy): _____

P1: Patient: Baseline Prostate Questionnaire Intact

Time points: Baseline

Data Elements	Options
The following questions pertain to your current state of health and basic factors about you:	
Using the scale below, circle one number that indicates how you feel about your current state of health	**0** to **5** to **10** **Very Poor** **Average** **Excellent**
Please select one response, which best describes you	• Married • Divorced • In a committed relationship • Widowed • Dating • Single
What is the highest level of education you have completed?	• Grade School or less • Some High School • High School Graduate or G.E.D • Some College or Technical School

	• Associate Degree • College Graduate (Bachelor's Degree) • Graduate Degree
What is your current household income?	• Under $50,000 • $50,000-$100,000 • $100,000-$300,000 • Over $300,0000
Assessment of Cannabis Use	
Have you ever, even once, used Cannabis?	• Prefer not to answer – Proceed to question 9 • No – Proceed to question 9 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- Proceed to Question 9 • 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
Please answer the following questions by checking the appropriate answer. All questions are about your health and symptoms in the last four weeks	
Over the past 4 weeks, how often have you leaked	• More than once a day

urine?	• About once a day • More than once a week • About once a week • Rarely or never
Which of the following best describes your urinary control during the last 4 weeks?	• No urinary control whatsoever • Frequent dribbling • Occasional dribbling • Total control
How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?	• None • 1 pad per day • 2 pads per day • 3 or more pads per day
How big a problem, if any, has each of the following been for you during the last 4 weeks? a. Dripping or leaking urine b. Pain or burning on urination c. Bleeding with urination d. Weak urine stream or in complete emptying e. Need to urinate frequently during the day	• No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4
Overall, how big a problem has your urinary function been for you during the last 4 weeks?	• No Problem • Very Small Problem • Small Problem • Moderate Problem • Big Problem

How big a problem, if any, has each of the following been for you? a. Rectal pain or urgency of bowel b. Increased frequency of your bowel c. Overall problems with your bowel d. Bloody stools	• No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4
How would you rate each of the following during the last 4 weeks? a. Your ability to have an erection? b. Your ability to reach orgasm (climax)?	• Very Poor to None - 0 • Poor - 1 • Fair - 2 • Good - 3 • Very Good - 4
How would you describe the usual QUALITY of your erections during the last 4 weeks?	• None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse
How would you describe the FREQUENCY of your erections during the last 4 weeks?	• I NEVER had an erection when I wanted one • I had an erection LESS THAN HALF the time I wanted one • I had an erection ABOUT HALF the time I wanted one • I had an erection MORE THAN HALF the time I wanted one • I had an erection WHENEVER I wanted one
Overall, how would you rate your ability to function sexually during the last 4 weeks?	• Very Poor • Poor • Fair • Good • Very good
Overall, how big a problem has your sexual function or	

lack of sexual function been for you during the last 4 weeks	• No Problem • Very small problem • Small problem • Moderate problem • Big problem
The following questions pertain to your sexual activity and use of erectile aids	
In the PAST 4 WEEKS, how interested have you been in sexual activity?	• Not at all • Somewhat • A little bit • Quite a bit • Very much
In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?	• 0 times (If selected, skip to question 21) • 1 time • 2 times • 3 times • 4 or more times
When you have had a sexual activity, how satisfying has it been?	• Not at all • A little bit • Somewhat • Quite a bit • Very much
Please select the erectile aids you may have used in the PAST 4 WEEKS for sexual activity. Please choose all that apply	• None • Pills (Viagra, Cialis, Levitra, Stendra, Sildenafil, Staxyn) • Urethral Suppository (MUSE) • Penile Injection • Vacuum Erection Device • Other (specify): _____
When you have been sexually active over the PAST 4 WEEKS, did you use erectile aids:	• Almost never/never • A few times (less than half of the time) • Sometimes (about half of the time) • Most times (more than half of the time) • Almost always/always

Why have you not been sexually active? Please choose all that apply.	• Lack of a willing partner • Lack of interest • Lack of confidence • No ejaculate • No erection • Urine leak during intercourse • Pain/discomfort during intercourse • Other (specify): _____
How big a problem, if any, has each of the following been for you? a. Hot flashes or breast tenderness/enlargement b. Feeling depressed c. Lack of energy	• No Problem - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem- 4
The following questions pertain to your pain management this past year	
Have you taken opioid/narcotic medications in the past year? (e.g. Tylenol-3, Vicodin, Oxycodone, etc.)	• Yes • No
Please rate your pain by selecting the one number that best describes your pain at its worst in the last week	**0** to **5** to **10** **Very Poor** **Average** **Worst Imaginable**
Please rate your pain by selecting the one number that best describes your pain at its average in the last week.	**0** to **5** to **10** **Very Poor** **Average** **Worst Imaginable**
The following questions pertain to your treatment plan	
Have you been told that SURGERY is	• More likely • Equally likely • less likely to cure your disease than radiation • n/a
Have you been told that RADIATION is	• More likely • Equally likely • less likely to cure your disease than surgery • n/a

What are your expectations on the number of side effects you will have during radiation therapy?	**0** to **5** to **10** **Almost none** **Moderate Amount** **Severe Side Effects**
How aggressive do you think your disease is?	**0** to **5** to **10** **Not Aggressive** **Somewhat Aggressive** **Very Aggressive**
On a scale of 1-10, how important are the following factors in making your treatment decision a. Cure b. Cost c. Quality of life d. Convenience e. Avoiding invasive procedures f. Erectile function g. Avoiding urinary leakage h. Avoiding urinary frequency i. Avoiding rectal problems j. Avoiding hormone therapy	**0** to **5** to **10** **Not Important** **Fairly Important** **Very Important**

P2: Patient: Baseline Prostate Questionnaire Post Op

Time points: Baseline

Data Elements	Options
The following questions pertain to your current state of health and basic factors about you:	
Using the scale below, circle one number that indicates how you feel about your current state of health	**0** to **5** to **10** **Very Poor** **Average** **Excellent**
Please select one response, which best describes you	• Married • Divorced • In a committed relationship • Widowed • Dating • Single
What is the highest level of education you have	• Grade School or less

completed?	• Some High School • High School Graduate or G.E.D • Some College or Technical School • Associate Degree • College Graduate (Bachelor's Degree) • Graduate Degree
What is your current household income?	• Under $50,000 • $50,000-$100,000 • $100,000-$300,000 • Over $300,0000
Assessment of Cannabis Use	
Have you ever, even once, used Cannabis?	• Prefer not to answer – Proceed to question 9 • No – Proceed to question 9 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- Proceed to Question 9 • 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
Please answer the following questions by checking the appropriate answer. All questions are about your health and symptoms in the last four weeks	

Over the past 4 weeks, how often have you leaked urine?	• More than once a day • About once a day • More than once a week • About once a week • Rarely or never
Which of the following best describes your urinary control during the last 4 weeks?	• No urinary control whatsoever • Frequent dribbling • Occasional dribbling • Total control
How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?	• None • 1 pad per day • 2 pads per day • 3 or more pads per day
How big a problem, if any, has each of the following been for you during the last 4 weeks? f. Dripping or leaking urine g. Pain or burning on urination h. Bleeding with urination i. Weak urine stream or in complete emptying j. Need to urinate frequently during the day	• No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4
Overall, how big a problem has your urinary function been for you during the last 4 weeks?	• No Problem • Very Small Problem • Small Problem • Moderate Problem • Big Problem

How big a problem, if any, has each of the following been for you? e. Rectal pain or urgency of bowel f. Increased frequency of your bowel g. Overall problems with your bowel h. Bloody stools	• No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4
How would you rate each of the following during the last 4 weeks? c. Your ability to have an erection? d. Your ability to reach orgasm (climax)?	• Very Poor to None - 0 • Poor - 1 • Fair - 2 • Good - 3 • Very Good - 4
How would you describe the usual QUALITY of your erections during the last 4 weeks?	• None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse
How would you describe the FREQUENCY of your erections during the last 4 weeks?	• I NEVER had an erection when I wanted one • I had an erection LESS THAN HALF the time I wanted one • I had an erection ABOUT HALF the time I wanted one • I had an erection MORE THAN HALF the time I wanted one • I had an erection WHENEVER I wanted one
Overall, how would you rate your ability to function sexually during the last 4 weeks?	• Very Poor • Poor • Fair • Good • Very good

Overall, how big a problem has your sexual function or lack of sexual function been for you during the last 4 weeks	• No Problem • Very small problem • Small problem • Moderate problem • Big problem
The following questions pertain to your sexual activity and use of erectile aids	
In the PAST 4 WEEKS, how interested have you been in sexual activity?	• Not at all • Somewhat • A little bit • Quite a bit • Very much
In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?	• 0 times (If selected, skip to question 21) • 1 time • 2 times • 3 times • 4 or more times
When you have had a sexual activity, how satisfying has it been?	• Not at all • A little bit • Somewhat • Quite a bit • Very much
Please select the erectile aids you may have used in the PAST 4 WEEKS for sexual activity. Please choose all that apply	• None • Pills (Viagra, Cialis, Levitra, Stendra, Sildenafil, Staxyn) • Urethral Suppository (MUSE) • Penile Injection • Vacuum Erection Device • Other (specify): _____
When you have been sexually active over the PAST 4 WEEKS, did you use erectile aids:	• Almost never/never • A few times (less than half of the time) • Sometimes (about half of the time) • Most times (more than half of the time) • Almost always/always

Why have you not been sexually active? Please choose all that apply.	• Lack of a willing partner • Lack of interest • Lack of confidence • No ejaculate • No erection • Urine leak during intercourse • Pain/discomfort during intercourse • Other (specify): _____
How big a problem, if any, has each of the following been for you? d. Hot flashes or breast tenderness/enlargement e. Feeling depressed f. Lack of energy	• No Problem - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem- 4
The following questions pertain to your pain management this past year	
Have you taken opioid/narcotic medications in the past year? (e.g. Tylenol-3, Vicodin, Oxycodone, etc.)	• Yes • No
Please rate your pain by selecting the one number that best describes your pain at its worst in the last week	**0** to **5** to **10** **Very Poor** **Average** **Worst Imaginable**
Please rate your pain by selecting the one number that best describes your pain at its average in the last week.	**0** to **5** to **10** **Very Poor** **Average** **Worst Imaginable**
The following questions pertain to your treatment plan	
Did you see a radiation oncologist prior to undergoing surgery?	• Yes/No
Were you told prior to surgery that you may need radiation therapy after surgery? If yes, how likely did they tell you that you would need radiation therapy?	• Yes/No

	0 to **5** to **10** **Not Likely** **Somewhat Likely** **Very Likely**
Do you regret having surgery and would have rather had radiation therapy?	• Yes/No
Treatment and cancer understanding	
Have you been told that SURGERY is	• More likely • Equally likely • less likely to cure your disease than radiation • n/a
Have you been told that RADIATION is	• More likely • Equally likely • less likely to cure your disease than surgery • n/a
What are your expectations on the number of side effects you will have during radiation therapy?	**0** to **5** to **10** **Almost none** **Moderate Amount** **Severe Side Effects**
How aggressive do you think your disease is?	**0** to **5** to **10** **Not Aggressive** **Somewhat Aggressive** **Very Aggressive**
On a scale of 1-10, how important are the following factors in making your treatment decision a. Cure b. Cost c. Quality of life d. Convenience e. Avoiding invasive procedures f. Erectile function g. Avoiding urinary leakage h. Avoiding urinary frequency i. Avoiding rectal problems	**0** to **5** to **10** **Not Important** **Fairly Important** **Very Important**

j. Avoiding hormone therapy	

P3: Physician: Androgen Deprivation Therapy

Time points: Baseline

Data Elements	Options
Did the patient receive androgen deprivation therapy (ADT) prior to being seen in Radiation Oncology for consultation	• Yes/No
Did you recommend the patient receive ADT?	• Yes/No
Is the patient going to receive ADT?	• Yes • No • Patient refused ADT (if no, proceed to question 5)
a. If yes, select type (check as many as relevant)	• LHRH agonist • LHRH antagonist • Bicalutamide • Abiraterone • Enzalutamide • Apalutamide • Daralutamide • LHRH antagonist oral (e.g Relugolix [Orgovyx])
b. Check all components of sequencing of ADT in relation to radiotherapy you intend to give (check all that apply)?	• Neoadjuvant • Concurrent • Adjuvant • Intended total duration (months) _____
Is this patient enrolled on any prostate cancer clinical trial that dictates dose of radiotherapy or use of systemic therapy (do not include MROQC)?	• Yes/No
What is the patient's most recent PSA value prior to starting radiation or hormone therapy?	ng/mL

What is the date of the most recent PSA value prior to starting radiation or hormone therapy?	m/dd/yy
Was PET imaging obtained prior to the current treatment plan? a) If yes, what was the imaging scan type? b) Scan results (check all that apply):	• Yes/No • PSMA / Axumin • Negative / Local / Regional LNs
Were tissue-based genomics obtained prior to the current treatment plan? a. If yes, what was the genomic test type?	• Yes/No • Decipher • Prolaris • Oncotype
Was a prostate or pelvic MRI obtained within 6 months of treatment? If yes, check all that apply: a) ECE: ❑ Yes ❑ Equivocal ❑ No b) SVI: ❑ Yes ❑ Equivocal ❑ No c) Nodal metastasis: ❑ Yes ❑ Equivocal ❑ No d) None of above/negative MRI Scan	• Yes/No
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?	• Yes/No

P4: CDA: Prostate Baseline Form Questionnaire	
	Time points: Baseline
Data Elements	**Options**
How would you describe the usual QUALITY of your erections during the last 4 weeks?	• None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse
Overall, how big a problem has your urinary habits been for you during the last 4 weeks?	• No problem • Very small problem • Small problem • Moderate problem • Big problem
Overall, how big a problem have your bowel habits been for your during the last 4 weeks	• No problem • Very small problem • Small problem • Moderate problem • Big problem
P5: Patient: Follow-up Prostate Questionnaire	
	Time points: Follow-up visits 6 months-12 months-24 months-60 months
Data Elements	**Options**
Over the past 4 weeks, how often have you leaked urine?	• More than once a day • About once a day • More than once a week • About once a week • Rarely or never
Which of the following best describes your urinary control during the last 4 weeks?	• No urinary control whatsoever • Frequent dribbling • Occasional dribbling • Total control
How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?	• None • 1 pad per day • 2 pads per day

	• 3 or more pads per day
How big a problem, if any, has each of the following been for you during the last 4 weeks? a. Dripping or leaking urine b. Pain or burning on urination c. Bleeding with urination d. Weak urine stream or in complete emptying e. Need to urinate frequently during the day	• No - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem - 4
Overall, how big a problem has your urinary function been for you during the last 4 weeks?	• No problem • Very small problem • Small problem • Moderate problem • Big problem
How big a problem, if any, has each of the following been for you? a. Rectal pain or urgency of bowel b. Increased frequency of your c. Overall problems with your bowel d. Bloody stools	• No - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem - 4
How would you rate each of the following during the last 4 weeks? a. Your ability to have an erection? b. Your ability to reach orgasm (climax)?	• Very Poor to None – 0 • Poor - 1 • Fair - 2 • Good – 3 • Very Good - 4
How would you describe the usual QUALITY of your erections during the last 4 weeks?	• None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse

How would you describe the FREQUENCY of your erections during the last 4 weeks?	• I NEVER had an erection when I wanted one • I had an erection LESS THAN HALF the time I wanted one • I had an erection ABOUT HALF the time I wanted one • I had an erection MORE THAN HALF the time I wanted one • I had an erection WHENEVER I wanted one
Overall, how would you rate your ability to function sexually during the last 4 weeks?	• Very poor • Poor • Fair • Good • Very good
Overall, how big a problem has your sexual function or lack of sexual function been of you **during the last 4 weeks?**	• No problem • Very small problem • Small problem • Moderate problem • Big problem
The following questions pertain to your sexual activity and use of erectile aids	
In the PAST 4 WEEKS, how interested have you been in sexual activity?	• Not at all • Somewhat • A little bit • Quite a bit • Very much
In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?	• 0 times (If selected, skip to question 17) • 1 time • 2 times • 3 times • 4 or more times
When you have had a sexual activity, how satisfying has it been?	• Not at all • A little bit • Somewhat • Quite a bit

	• Very much
Please select the erectile aids you may have used in the PAST 4 WEEKS for sexual activity. Please choose all that apply	• None • Pills (Viagra, Cialis, Levitra, Stendra, Sildenafil, Staxyn) • Urethral Suppository (MUSE) • Penile Injection • Vacuum Erection Device • Other (specify): _____
When you have been sexually active over the PAST 4 WEEKS, did you use erectile aids	• Almost never/never • A few times (less than half of the time) • Sometimes (about half of the time) • Most times (more than half of the time) • Almost always/always
Why have you not been sexually active? Please choose all that apply	• Lack of a willing partner • Lack of interest • Lack of confidence • No ejaculate • No erection • Urine leak during intercourse • Pain/discomfort during intercourse • Other (specify): _____
How big a problem, if any, has each of the following been for you? a. Hot flashes or breast tenderness/enlargement b. Feeling depressed c. Lack of energy	• No - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem - 4
The following questions pertain to the status of your cancer	
Has your cancer returned after radiotherapy?	• Yes/No
Do you know what your most recent PSA was? a. If yes, value b. Approximate date PSA was drawn	• Yes/No _____ (mm/yyyy)

If you believe your cancer has returned, has a scan (CT, bone scan, PET scan, or MRI) shown that it has spread or metastasized ? a. Approximate date of the scan	• Yes/No (mm/yyyy)
The following questions pertain to your feelings about the treatment you chose	
If you did not have surgery initially and had radiation therapy, do you wish you had chosen to have surgery instead?	• Yes • No • N/A
If you did have surgery initially, do you wish you had chosen radiation therapy instead?	• Yes • No • N/A
Are you pleased with the physician who treated your cancer with radiation therapy?	• Yes • No
How likely are you to recommend a patient receive radiotherapy for a cancer like you had?	**0** to **5** to **10** **Not Likely** **Somewhat Likely** **Very Likely**
How were the side effects of treatment compared to your initial expectations?	**0** to **5** to **10** **Worse Than Expected** **As Expected** **Better Than Expected**
Now that you have completed treatment, do you feel you are able to return to your normal lifestyle? a. If no, is this due to side effects from radiation therapy? b. If no, is this due to side effects from hormone therapy?	• Yes/No • Yes/No • Yes/No/NA

The following question pertains to your current state of health:	
Using the scale below, circle one number that indicates how you feel about your current state of health	**0** to **5** to **10** **Very Poor** **Average** **Excellent**

P6: CDA: Prostate Follow-up Data Collection

Time points: Follow-up visits 6 months-12 months-24 months-36 months-60 months

Data Elements	Options
PSA Results Test Date Test Value	• PSA Test Not Done • mm/dd/yyyy • ng/ml
Metastatic disease	
1. Has the patient had any imaging done that demonstrates the development of metastatic disease? a. Date of scan	• Yes • No • Previously documented (mm/dd/yyyy)
If the patient's development of metastatic disease was documented on a previous follow-up form, select previously documented and proceed to question 2.	
Androgen Deprivation Therapy	
2. Was the patient treated with RT combined with ADT?	• Yes • No • Previously documented
a. If yes, is the patient still on ADT?	• Yes • No

If the patient's duration on ADT (question 2c) was documented on a previous follow-up form, select previously documented and proceed to question 3.	
b. If the patient is <u>currently on ADT</u> select the medications and provide the start date (mm/yyyy)	• LHRH agonist (e.g. Leuprolide, Goserelin)-start date: _____ • LHRH antagonist (e.g. Firmagon)-start date: _____ • Bicalutamide-start date: _____ • Abiteraterone-start date: _____ • Enzalutamide- start date: _____ • Apalutamide-start date: _____ • Daralutamide-start date: _____
c. If the patient has completed ADT, list the total number of months ADT was actually delivered	months
Additional Treatment	
3. Was additional cancer therapy for recurrence given after RT?	• Yes • No
a. If yes, check all that apply including start date (mm/yyyy)	• Chemotherapy-start date: _____ • Leuprolide, Goserelin, bicalutamide, or firmagon-start date: _____ • Abiteraterone-start date: _____ • Enzalutamide-start date: _____ • Apalutamide-start date: _____ • Daralutamide-start date: _____
Was there a local recurrence?	• Yes • No
a. If YES, was additional local therapy given for recurrence	• Yes • No
b. If yes, select the additional therapy given	• Salvage external beam reirradiation • Salvage brachytherapy • Salvage surgery • Salvage cryosurgery

	• Salvage high-intensity focused ultrasound (HIFU)
c. Treatment start date	mm/yyyy
Was there a regional or distant recurrence?	• Yes • No
a. If YES, was additional RT given to metastatic site?	• Yes • No
b. Treatment start date	(mm/yyyy)

P7: CDA: Baseline Clinical Data

P7 form should be completed by sites without a referring MUSIC practice. Time points: Baseline

Data Elements	**Options**
Weight (specify lbs or kg)	_____
Metastatic disease	
BMI (specify inches or cm) or Height *If you do not have access to the height and weight, please ask the patient.	_____
<u>Tumor Characteristic</u>	
Clinical Tumor Stage	• T • N
<u>Prostate Biopsy</u>	
Biopsy Date (mm/dd/yyyy)	_____ a) Gleason pattern-primary _____ b) Gleason pattern-secondary_____ c) Total biopsy cores positive _____ d) Total biopsy core negative _____

MRI/CT performed?	• Not Performed • Negative • Positive
Bone scan performed?	• Not Performed • Negative • Positive
PSA Value	
What is the patient's most recent PSA value prior to any cancer treatment?	_____**ng/ml**
What is the date of the most recent PSA value prior to any cancer treatment?	mm/dd/yyy
Comorbidities	
Hypertension Diabetes mellitus Scleroderma Rheumatoid Arthritis Lupus Cerebrovascular disease Chronic pulmonary disease Congestive heart failure Connective tissue disease Confusion Hemiplegia Leukemia Malignant lymphoma Myocardial infarction Peripheral vascular disease Ulcer disease Liver disease Renal disease	• Yes • No

Malignant solid tumor (other than breast) AIDS Dementia	
Is this a post-operative patient? **(If, yes answer questions 9-15)**	• Yes • No
Surgery date	(mm/dd/yyyy)
Pathologic stage	• T • N
Extraprostatic extension	• Yes • No
Seminal vesicle invasion	• Yes • No
Surgical margins	• Positive • Negative
What is the patient's most recent PSA value post radical prostatectomy?	ng/mL
What is the date of the most recent PSA value post radical prostatectomy?	(mm/dd/yyyy)

Prostate Radiotherapy Technical Details Form

Time points: End of Treatment

Data Elements	**Options**
Brachytherapy/EBRT Details	

[Q1] Select the treatment type	• External Beam Radiation Therapy (EBRT) alone • Brachytherapy alone (as monotherapy) • Combination therapy of EBRT and brachytherapy
Enter the start date of External Beam Radiation Therapy	[If Q1="EBRT" or "Combination therapy"]
Enter the end date of External Beam Radiation Therapy	[If Q1="EBRT" or "Combination therapy"]
[Q4] Indicate brachytherapy dose rate type	[If Q1=" Brachytherapy alone" or "Combination therapy"] • HDR • LDR
Indicate source type	[If Q1=" Brachytherapy alone" or "Combination therapy"] • Iridium-192 • Palladium-103 • Iodine-125 • Cesium-131 • Other. Please specify: _____
Total prescribed brachytherapy dose	[If Q1=" Brachytherapy alone" or "Combination therapy"] [between 1 and 90] _____Gy
Enter the date of LDR brachytherapy implant	[If Q4="LDR"]
Select the number of HDR brachytherapy fractions delivered	[If Q4="LDR"] [radio buttons] • 1 • 2 • 3 • 4

Enter the date(s) of HDR brachytherapy treatment	_____
Indicate any placement procedures prior to simulation related to radiation therapy delivery. Check all that apply	[If Q1="EBRT" or "Combination therapy"] • Gold fiducials • Rectal spacer • Radiofrequency beacons • Rectal balloon • None • Other. Please specify: _____
Which modalities were used for target delineation for EBRT treatment? Check all that apply.	[If Q1="EBRT" or "Combination therapy"] • CT simulation • PET • MRI • Ultrasound • Other. Please specify: _____
Which modalities were used for target delineation for brachytherapy treatment? Check all that apply.	[If Q1="Brachytherapy alone" or "Combination therapy"] • CT simulation • PET • MRI • Ultrasound • Other. Please specify: _____
Plan Details	
[Q13] How many EBRT plans were treated? For each plan, specify: a. What volumes were treated by this plan? Check all that apply.	[If Q1="External Beam Radiation Therapy" or "Combination therapy"] [drop-down menu 0-5] • Primary target (prostate or prostate bed) • Pelvic nodes • Seminal vesicles • Focal boost of prostate or prostate bed • Lymph node boost

b. Was a PRIMARY TARGET CTV structure defined?	[If Q13a="Primary target"] • Yes • No
c. Was a uniform margin used for the PRIMARY TARGET PTV?	[If Q13b="Yes"] • Yes • No
d. Specify the uniform margin between the PRIMARY TARGET CTV structure and PTV structure in cm	[If Q13c="Yes"] _____ cm
e. Specify the non-uniform margin between the PRIMARY TARGET CTV structure and PTV structure in cm:	[If Q13c="No"] Superior _____ Anterior _____ Right _____ Inferior _____ Posterior _____ Left _____
f. Dose delivered to the PRIMARY TARGET by this plan	[If Q13a="Primary target"] [between 1 and 90]
g. Number of fractions delivered to the PRIMARY TARGET by this plan	[If Q13a="Primary target"]
h. If pelvic nodes were treated, what was the timing used?	[If Q13a="Pelvic nodes"] • Simultaneous with primary target • Sequential plans
i. Was a NODAL CTV structure defined?	[If Q13a="Pelvic nodes"] • Yes • No
j. Was a uniform margin used for the NODAL PTV?	• Yes • No

k. Specify the uniform margin between the NODAL CTV structure and PTV structure in cm	[If Q13j="Yes"] _____ cm
l. Specify the non-uniform margin between the NODAL CTV structure and PTV structure in cm:	[If Q13j="No"] Superior _____ Anterior _____ Right _____ Inferior _____ Posterior _____ Left _____
m. Dose delivered to the PELVIC NODES by this plan	[If Q13a="Pelvic nodes"] [between 1 and 90] _____ Gy
n. Number of fractions delivered to the PELVIC NODES by this plan	[If Q13a="Pelvic nodes"]
o. Dose delivered to the SEMINAL VESICLES by this plan	[If Q13a="Seminal vesicles"] [between 1 and 90] _____ Gy
p. Number of fractions delivered to the SEMINAL VESICLES by this plan	[If Q13a="Seminal vesicles"]
q. Dose delivered for the PROSTATE OR PROSTATE BED BOOST by this plan:	[If Q13a="Focal boost of the prostate or prostate bed"] [between 1 and 90] _____ Gy
r. Number of fractions delivered for the PROSTATE OR PROSTATE BED BOOST by this plan	[If Q13a="Focal boost of the prostate or prostate bed"]
s. Dose delivered for the LN BOOST by this plan:	[If Q13a="Lymph node boost"] [between 1 and 90] _____ Gy
t. Number of fractions delivered for the LN BOOST by this plan	[If Q13a="Lymph node boost"]
u. Enter the name of the target prescribed to by this plan	_____ [free text field]
v. Did the patient receive all of the planned dose?	• Yes • No

w. Planning type used to create this plan x. Delivery type of this plan	• Forward planning • Inverse planning • 3D • IMRT • Rotational technique (VMAT or TomoTherapy) • Protons
Treatment Delivery and Image Guidance	
What type of imaging was used to verify this patient's setup? Check all that apply.	• kV/MV portal • CT (CBCT or TomoTherapy CT) • MR guidance directly before treatment • Ultrasound • Other. Please specify: _____
For each imaging type, specify how often the patient was imaged during treatment.	[Provide drop-down menu for each response selected in Q14] • Daily • Less than daily but more than weekly • Weekly • Other. Please specify: _____
Was real-time guidance used during treatment?	• Yes • No
What type of real-time guidance was used? Check all that apply.	[If Q16="Yes"] • Real-time kV tracking (such as based on fiducials) • MR guidance during treatment • Calypso radiofrequency system • Other. Please specify: _____