



Michigan Radiation Oncology Quality Consortium

MROQC Prostate Data Elements Guide

	<ul style="list-style-type: none"> • Associate Degree • College Graduate (Bachelor’s Degree) • Graduate Degree
What is your current household income?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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.)	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • More than once a day

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<p>urine?</p>	<ul style="list-style-type: none"> • About once a day • More than once a week • About once a week • Rarely or never
<p>Which of the following best describes your urinary control during the last 4 weeks?</p>	<ul style="list-style-type: none"> • No urinary control whatsoever • Frequent dribbling • Occasional dribbling • Total control
<p>How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?</p>	<ul style="list-style-type: none"> • None • 1 pad per day • 2 pads per day • 3 or more pads per day
<p>How big a problem, if any, has each of the following been for you during the last 4 weeks?</p> <ol style="list-style-type: none"> 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 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4 </div>
<p>Overall, how big a problem has your urinary function been for you during the last 4 weeks?</p>	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No Problem • Very Small Problem • Small Problem • Moderate Problem • Big Problem </div>

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<p>How big a problem, if any, has each of the following been for you?</p> <ul style="list-style-type: none"> a. Rectal pain or urgency of bowel b. Increased frequency of your bowel c. Overall problems with your bowel d. Bloody stools 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4 </div>
<p>How would you rate each of the following during the last 4 weeks?</p> <ul style="list-style-type: none"> a. Your ability to have an erection? b. Your ability to reach orgasm (climax)? 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • Very Poor to None - 0 • Poor - 1 • Fair - 2 • Good - 3 • Very Good - 4 </div>
<p>How would you describe the usual QUALITY of your erections during the last 4 weeks?</p>	<ul style="list-style-type: none"> • None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse
<p>How would you describe the FREQUENCY of your erections during the last 4 weeks?</p>	<ul style="list-style-type: none"> • 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
<p>Overall, how would you rate your ability to function sexually during the last 4 weeks?</p>	<ul style="list-style-type: none"> • Very Poor • Poor • Fair • Good • Very good
<p>Overall, how big a problem has your sexual function or</p>	

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<p>lack of sexual function been for you during the last 4 weeks</p>	<ul style="list-style-type: none"> • No Problem • Very small problem • Small problem • Moderate problem • Big problem
<p>The following questions pertain to your sexual activity and use of erectile aids</p>	
<p>In the PAST 4 WEEKS, how interested have you been in sexual activity?</p>	<ul style="list-style-type: none"> • Not at all • Somewhat • A little bit • Quite a bit • Very much
<p>In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?</p>	<ul style="list-style-type: none"> • 0 times (If selected, skip to question 21) • 1 time • 2 times • 3 times • 4 or more times
<p>When you have had a sexual activity, how satisfying has it been?</p>	<ul style="list-style-type: none"> • Not at all • A little bit • Somewhat • Quite a bit • Very much
<p>Please select the erectile aids you may have used in the PAST 4 WEEKS for sexual activity. Please choose all that apply</p>	<ul style="list-style-type: none"> • None • Pills (Viagra, Cialis, Levitra, Stendra, Sildenafil, Staxyn) • Urethral Suppository (MUSE) • Penile Injection • Vacuum Erection Device • Other (specify): _____
<p>When you have been sexually active over the PAST 4 WEEKS, did you use erectile aids:</p>	<ul style="list-style-type: none"> • 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

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<p>Why have you not been sexually active? Please choose all that apply.</p>	<ul style="list-style-type: none"> • 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): _____
<p>How big a problem, if any, has each of the following been for you?</p> <p>a. Hot flashes or breast tenderness/enlargement</p> <p>b. Feeling depressed</p> <p>c. Lack of energy</p>	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No Problem - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem- 4 </div>
<p>The following questions pertain to your pain management this past year</p>	
<p>Have you taken opioid/narcotic medications in the past year? (e.g. Tylenol-3, Vicodin, Oxycodone, etc.)</p>	<ul style="list-style-type: none"> • Yes • No
<p>Please rate your pain by selecting the one number that best describes your pain at its worst in the last week</p>	<p style="text-align: center;">0 to 5 to 10</p> <p style="text-align: center;">Very Poor Average Worst Imaginable</p>
<p>Please rate your pain by selecting the one number that best describes your pain at its average in the last week.</p>	<p style="text-align: center;">0 to 5 to 10</p> <p style="text-align: center;">Very Poor Average Worst Imaginable</p>
<p>The following questions pertain to your treatment plan</p>	
<p>Have you been told that SURGERY is</p>	<ul style="list-style-type: none"> • More likely • Equally likely • less likely to cure your disease than radiation • n/a
<p>Have you been told that RADIATION is</p>	<ul style="list-style-type: none"> • More likely • Equally likely • less likely to cure your disease than surgery • n/a

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<p>What are your expectations on the number of side effects you will have during radiation therapy?</p>	<p>0 to 5 to 10 Almost none Moderate Amount Severe Side Effects</p>
<p>How aggressive do you think your disease is?</p>	<p>0 to 5 to 10 Not Aggressive Somewhat Aggressive Very Aggressive</p>
<p>On a scale of 1-10, how important are the following factors in making your treatment decision</p> <ul style="list-style-type: none"> 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 	<p>0 to 5 to 10 Not Important Fairly Important Very Important</p>
<p>P2: Patient: Baseline Prostate Questionnaire Post Op</p>	
<p><i>Time points: Baseline</i></p>	
<p>Data Elements</p>	<p>Options</p>
<p>The following questions pertain to your current state of health and basic factors about you:</p>	
<p>Using the scale below, circle one number that indicates how you feel about your current state of health</p>	<p>0 to 5 to 10 Very Poor Average Excellent</p>
<p>Please select one response, which best describes you</p>	<ul style="list-style-type: none"> • Married • Divorced • In a committed relationship • Widowed • Dating • Single
<p>What is the highest level of education you have</p>	<ul style="list-style-type: none"> • Grade School or less



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<p>completed?</p>	<ul style="list-style-type: none"> • Some High School • High School Graduate or G.E.D • Some College or Technical School • Associate Degree • College Graduate (Bachelor’s Degree) • Graduate Degree
<p>What is your current household income?</p>	<ul style="list-style-type: none"> • Under \$50,000 • \$50,000-\$100,000 • \$100,000-\$300,000 • Over \$300,0000
<p>Assessment of Cannabis Use</p>	
<p>Have you ever, even once, used Cannabis?</p>	<ul style="list-style-type: none"> • Prefer not to answer – Proceed to question 9 • No – Proceed to question 9 Yes
<p>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?</p>	<ul style="list-style-type: none"> • 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
<p>During the past 30 days, which one of the following ways did you use cannabis most often? Did you usually:</p>	<ul style="list-style-type: none"> • 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: _____)
<p>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.)</p>	<ul style="list-style-type: none"> • THC –also called tetrahydrocannabinol • CBD –also called cannabidiol • Balanced levels of THC and CBD I don’t know
<p>Please answer the following questions by checking the appropriate answer. All questions are about your health and symptoms in the last four weeks</p>	

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<p>Over the past 4 weeks, how often have you leaked urine?</p>	<ul style="list-style-type: none"> • More than once a day • About once a day • More than once a week • About once a week • Rarely or never
<p>Which of the following best describes your urinary control during the last 4 weeks?</p>	<ul style="list-style-type: none"> • No urinary control whatsoever • Frequent dribbling • Occasional dribbling • Total control
<p>How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?</p>	<ul style="list-style-type: none"> • None • 1 pad per day • 2 pads per day • 3 or more pads per day
<p>How big a problem, if any, has each of the following been for you during the last 4 weeks?</p> <ul style="list-style-type: none"> 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 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4 </div>
<p>Overall, how big a problem has your urinary function been for you during the last 4 weeks?</p>	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No Problem • Very Small Problem • Small Problem • Moderate Problem • Big Problem </div>

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<p>How big a problem, if any, has each of the following been for you?</p> <ul style="list-style-type: none"> e. Rectal pain or urgency of bowel f. Increased frequency of your bowel g. Overall problems with your bowel h. Bloody stools 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No - 0 • Very Small Problem - 1 • Small - 2 • Moderate Problem - 3 • Big - 4 </div>
<p>How would you rate each of the following during the last 4 weeks?</p> <ul style="list-style-type: none"> c. Your ability to have an erection? d. Your ability to reach orgasm (climax)? 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • Very Poor to None - 0 • Poor - 1 • Fair - 2 • Good - 3 • Very Good - 4 </div>
<p>How would you describe the usual QUALITY of your erections during the last 4 weeks?</p>	<ul style="list-style-type: none"> • None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse
<p>How would you describe the FREQUENCY of your erections during the last 4 weeks?</p>	<ul style="list-style-type: none"> • 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
<p>Overall, how would you rate your ability to function sexually during the last 4 weeks?</p>	<ul style="list-style-type: none"> • Very Poor • Poor • Fair • Good • Very good

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<p>Overall, how big a problem has your sexual function or lack of sexual function been for you during the last 4 weeks</p>	<ul style="list-style-type: none"> • No Problem • Very small problem • Small problem • Moderate problem • Big problem
<p>The following questions pertain to your sexual activity and use of erectile aids</p>	
<p>In the PAST 4 WEEKS, how interested have you been in sexual activity?</p>	<ul style="list-style-type: none"> • Not at all • Somewhat • A little bit • Quite a bit • Very much
<p>In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?</p>	<ul style="list-style-type: none"> • 0 times (If selected, skip to question 21) • 1 time • 2 times • 3 times • 4 or more times
<p>When you have had a sexual activity, how satisfying has it been?</p>	<ul style="list-style-type: none"> • Not at all • A little bit • Somewhat • Quite a bit • Very much
<p>Please select the erectile aids you may have used in the PAST 4 WEEKS for sexual activity. Please choose all that apply</p>	<ul style="list-style-type: none"> • None • Pills (Viagra, Cialis, Levitra, Stendra, Sildenafil, Staxyn) • Urethral Suppository (MUSE) • Penile Injection • Vacuum Erection Device • Other (specify): _____
<p>When you have been sexually active over the PAST 4 WEEKS, did you use erectile aids:</p>	<ul style="list-style-type: none"> • 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



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	<p>0 to 5 to 10</p> <p>Not Likely Somewhat Likely Very Likely</p>
Do you regret having surgery and would have rather had radiation therapy?	<ul style="list-style-type: none"> • Yes/No
Treatment and cancer understanding	
Have you been told that SURGERY is	<ul style="list-style-type: none"> • More likely • Equally likely • less likely to cure your disease than radiation • n/a
Have you been told that RADIATION is	<ul style="list-style-type: none"> • 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?	<p>0 to 5 to 10</p> <p>Almost none Moderate Amount Severe Side Effects</p>
How aggressive do you think your disease is?	<p>0 to 5 to 10</p> <p>Not Aggressive Somewhat Aggressive Very Aggressive</p>
On a scale of 1-10, how important are the following factors in making your treatment decision	
<ul style="list-style-type: none"> 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 	<p>0 to 5 to 10</p> <p>Not Important Fairly Important Very Important</p>

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j. Avoiding hormone therapy	
P3: Physician: Androgen Deprivation Therapy	
<i>Time points: Baseline</i>	
Data Elements	Options
Did the patient receive androgen deprivation therapy (ADT) prior to being seen in Radiation Oncology for consultation	<ul style="list-style-type: none"> • Yes/No
Did you recommend the patient receive ADT?	<ul style="list-style-type: none"> • Yes/No
<p>Is the patient going to receive ADT?</p> <p>a. If yes, select type (check as many as relevant)</p> <p>b. Check all components of sequencing of ADT in relation to radiotherapy you intend to give (check all that apply)?</p>	<ul style="list-style-type: none"> • Yes • No • Patient refused ADT (if no, proceed to question 5) • LHRH agonist • LHRH antagonist • Bicalutamide • Abiraterone • Enzalutamide • Apalutamide • Darolutamide • LHRH antagonist oral (e.g Relugolix [Orgovyx]) • Neoadjuvant • Concurrent • Adjuvant • Intended total duration (months) _____
Is ADT being used solely for cytoreduction?	<ul style="list-style-type: none"> • Yes/No
Is this patient enrolled on any prostate cancer clinical trial that dictates dose of radiotherapy or use of systemic therapy (do not include MROQC)?	<ul style="list-style-type: none"> • Yes/No
What is the patient's most recent PSA value prior to starting radiation or hormone therapy?	ng/mL

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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? If yes, what was the imaging scan type?	<ul style="list-style-type: none"> • Yes/No
Was this patient counseled by a doctor or other healthcare worker about quitting cigarettes?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • No problem • Very small problem • Small problem • Moderate problem • Big problem
Overall, how big a problem have your bowel habits been for you during the last 4 weeks?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • More than once a day • About once a day • More than once a week

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	<ul style="list-style-type: none"> • About once a week • Rarely or never
<p>Which of the following best describes your urinary control during the last 4 weeks?</p>	<ul style="list-style-type: none"> • No urinary control whatsoever • Frequent dribbling • Occasional dribbling • Total control
<p>How many pads or adult diapers per day did you usually use to control leakage during the last 4 weeks?</p>	<ul style="list-style-type: none"> • None • 1 pad per day • 2 pads per day • 3 or more pads per day
<p>How big a problem, if any, has each of the following been for you during the last 4 weeks?</p> <ol style="list-style-type: none"> 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 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem - 4 </div>
<p>Overall, how big a problem has your urinary function been for you during the last 4 weeks?</p>	<ul style="list-style-type: none"> • No problem • Very small problem • Small problem • Moderate problem • Big problem
<p>How big a problem, if any, has each of the following been for you?</p> <ol style="list-style-type: none"> a. Rectal pain or urgency of bowel b. Increased frequency of your c. Overall problems with your bowel d. Bloody stools 	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • No - 0 • Very Small Problem - 1 • Small Problem - 2 • Moderate Problem - 3 • Big Problem - 4 </div>

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<p>How would you rate each of the following during the last 4 weeks?</p> <p>a. Your ability to have an erection?</p> <p>b. Your ability to reach orgasm (climax)?</p>	<div style="border: 1px solid black; padding: 10px;"> <ul style="list-style-type: none"> • Very Poor to None – 0 • Poor - 1 • Fair - 2 • Good – 3 • Very Good - 4 </div>
<p>How would you describe the usual QUALITY of your erections during the last 4 weeks?</p>	<ul style="list-style-type: none"> • None at all • Not firm enough for any sexual activity • Firm enough for masturbation and foreplay only • Firm enough for intercourse
<p>How would you describe the FREQUENCY of your erections during the last 4 weeks?</p>	<ul style="list-style-type: none"> • 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
<p>Overall, how would you rate your ability to function sexually during the last 4 weeks?</p>	<ul style="list-style-type: none"> • Very poor • Poor • Fair • Good • Very good
<p>Overall, how big a problem has your sexual function or lack of sexual function been of you during the last 4 weeks?</p>	<ul style="list-style-type: none"> • No problem • Very small problem • Small problem • Moderate problem • Big problem
<p>The following questions pertain to your sexual activity and use of erectile aids</p>	
<p>In the PAST 4 WEEKS, how interested have you been in sexual activity?</p>	<ul style="list-style-type: none"> • Not at all • Somewhat

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	<ul style="list-style-type: none"> • A little bit • Quite a bit • Very much
In the PAST 4 WEEKS, how many times have you tried to have any sexual activity?	<ul style="list-style-type: none"> • 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?	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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): _____



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<p>How were the side effects of treatment compared to your initial expectations?</p>	<p style="text-align: center;"> 0 to 5 to 10 Worse Than As Expected Better Than Expected Expected Expected </p>
<p>Now that you have completed treatment, do you feel you are able to return to your normal lifestyle?</p> <p>a. If no, is this due to side effects from radiation therapy?</p> <p>b. If no, is this due to side effects from hormone therapy?</p>	<ul style="list-style-type: none"> • Yes/No • Yes/No • Yes/No/NA
<p>The following question pertains to your current state of health:</p>	
<p>Using the scale below, circle one number that indicates how you feel about your current state of health</p>	<p style="text-align: center;"> 0 to 5 to 10 Very Poor Average Excellent </p>
<p>P6: CDA: Prostate Follow-up Data Collection</p>	
<p><i>Time points: Follow-up visits 6 months-12 months-24 months-36 months-60 months</i></p>	
<p>Data Elements</p>	<p>Options</p>
<p>PSA Results</p> <p>Test Date</p> <p>Test Value</p>	<ul style="list-style-type: none"> • PSA Test Not Done • mm/dd/yyyy • ng/ml
<p>Metastatic disease</p>	
<p>1. Has the patient had any imaging done that demonstrates the development of metastatic disease?</p> <p>a. Date of scan</p>	<ul style="list-style-type: none"> • Yes • No • Previously documented <p>(mm/dd/yyyy)</p>
<p>If the patient's development of metastatic disease was documented on a previous follow-up form, select previously documented and proceed to question 2.</p>	
<p>Androgen Deprivation Therapy</p>	

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<p>2. Was the patient treated with RT combined with ADT?</p> <p>a. If yes, is the patient still on ADT?</p>	<ul style="list-style-type: none"> • Yes • No • Previously documented <ul style="list-style-type: none"> • Yes • No
<p>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.</p>	
<p>b. If the patient is <u>currently on ADT</u> select the medications and provide the start date (mm/yyyy)</p> <p>c. If the patient has completed ADT, list the total number of months ADT was actually delivered</p>	<ul style="list-style-type: none"> • LHRH agonist (e.g. Leuprolide, Goserelin)-start date: _____ • LHRH antagonist (e.g. Firmagon)-start date: _____ • Bicalutamide-start date: _____ • Abiraterone-start date: _____ • Enzalutamide- start date: _____ • Apalutamide-start date: _____ • Darolutamide-start date: _____ <p>months</p>
<p>Additional Treatment</p>	
<p>3. Was additional cancer therapy for recurrence given after RT?</p> <p>a. If yes, check all that apply including start date (mm/yyyy)</p>	<ul style="list-style-type: none"> • Yes • No <ul style="list-style-type: none"> • Chemotherapy-start date: _____ • Leuprolide, Goserelin, bicalutamide, or firmagon-start date: _____ • Abiraterone-start date: _____ • Enzalutamide-start date: _____ • Apalutamide-start date: _____ • Darolutamide-start date: _____
<p>Was there a local recurrence?</p>	<ul style="list-style-type: none"> • Yes



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<p>a. If YES, was additional local therapy given for recurrence</p> <p>b. If yes, select the additional therapy given</p> <p>c. Treatment start date</p>	<ul style="list-style-type: none"> • No • Yes • No • Salvage external beam reirradiation • Salvage brachytherapy • Salvage surgery • Salvage cryosurgery • Salvage high-intensity focused ultrasound (HIFU) <p>mm/yyyy</p>
<p>Was there a regional or distant recurrence?</p> <p>a. If YES, was additional RT given to metastatic site?</p> <p>b. Treatment start date</p>	<ul style="list-style-type: none"> • Yes • No • Yes • No <p>(mm/yyyy)</p>
<p>P7: CDA: Baseline Clinical Data</p>	
<p><i>P7 form should be completed by sites without a referring MUSIC practice. Time points: Baseline</i></p>	
<p>Data Elements</p>	<p>Options</p>
<p>Weight (specify lbs or kg)</p>	<p>_____</p>
<p>Metastatic disease</p>	
<p>BMI (specify inches or cm) or Height *If you do not have access to the height and weight, please ask the patient.</p>	<p>_____</p>
<p>Tumor Characteristic</p>	
<p>Clinical Tumor Stage</p>	<ul style="list-style-type: none"> • T • N



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<u>Prostate Biopsy</u>	
Biopsy Date (mm/dd/yyyy)	<p>_____</p> <p>a) Gleason pattern-primary _____</p> <p>b) Gleason pattern-secondary _____</p> <p>c) Total biopsy cores positive _____</p> <p>d) Total biopsy core negative _____</p>
MRI/CT performed?	<ul style="list-style-type: none"> • Not Performed • Negative • Positive
Bone scan performed?	<ul style="list-style-type: none"> • Not Performed • Negative • Positive
<u>PSA Value</u>	
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/yyyy
<u>Comorbidities</u>	
<p>Hypertension</p> <p>Diabetes mellitus</p> <p>Scleroderma</p> <p>Rheumatoid Arthritis</p> <p>Lupus</p> <p>Cerebrovascular disease</p> <p>Chronic pulmonary disease</p> <p>Congestive heart failure</p>	<ul style="list-style-type: none"> • Yes • No

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<p>Connective tissue disease Confusion Hemiplegia Leukemia Malignant lymphoma Myocardial infarction Peripheral vascular disease Ulcer disease Liver disease Renal disease Malignant solid tumor (other than breast) AIDS Dementia</p>	
<p>Is this a post-operative patient? (If, yes answer questions 9-15)</p>	<ul style="list-style-type: none"> • Yes • No
<p>Surgery date</p>	<p>(mm/dd/yyyy)</p>
<p>Pathologic stage</p>	<ul style="list-style-type: none"> • T • N
<p>Extraprostatic extension</p>	<ul style="list-style-type: none"> • Yes • No
<p>Seminal vesicle invasion</p>	<ul style="list-style-type: none"> • Yes • No
<p>Surgical margins</p>	<ul style="list-style-type: none"> • Positive • Negative
<p>What is the patient's most recent PSA value post radical prostatectomy?</p>	<p>ng/mL</p>



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What is the date of the most recent PSA value post radical prostatectomy?	(mm/dd/yyyy)
Prostate Radiotherapy Technical Details Form	
<i>Time points: End of Treatment</i>	
Data Elements	Options
Brachytherapy/EBRT Details	
[Q1] Select the treatment type	<ul style="list-style-type: none"> • 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"] <ul style="list-style-type: none"> • HDR • LDR
Indicate source type	[If Q1=" Brachytherapy alone" or "Combination therapy"] <ul style="list-style-type: none"> • 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

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Enter the date of LDR brachytherapy implant	[If Q4="LDR"]
Select the number of HDR brachytherapy fractions delivered	[If Q4="LDR"] [radio buttons] <ul style="list-style-type: none"> • 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"] <ul style="list-style-type: none"> • 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"] <ul style="list-style-type: none"> • 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"] <ul style="list-style-type: none"> • CT simulation • PET • MRI • Ultrasound • Other. Please specify: _____
Plan Details	
[Q13] How many EBRT plans were treated?	[If Q1="External Beam Radiation Therapy" or "Combination therapy"] [drop-down menu 0-5]

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<p>For each plan, specify:</p> <p>a. What volumes were treated by this plan? Check all that apply.</p> <p>b. Was a PRIMARY TARGET CTV structure defined?</p> <p>c. Was a uniform margin used for the PRIMARY TARGET PTV?</p> <p>d. Specify the uniform margin between the PRIMARY TARGET CTV structure and PTV structure in cm</p> <p>e. Specify the non-uniform margin between the PRIMARY TARGET CTV structure and PTV structure in cm:</p> <p>f. Dose delivered to the PRIMARY TARGET by this plan</p> <p>g. Number of fractions delivered to the PRIMARY TARGET by this plan</p> <p>h. If pelvic nodes were treated, what was the timing used?</p> <p>i. Was a NODAL CTV structure defined?</p>	<ul style="list-style-type: none"> • Primary target (prostate or prostate bed) • Pelvic nodes • Seminal vesicles • Focal boost of prostate or prostate bed • Lymph node boost <p>[If Q13a="Primary target"]</p> <ul style="list-style-type: none"> • Yes • No <p>[If Q13b="Yes"]</p> <ul style="list-style-type: none"> • Yes • No <p>[If Q13c="Yes"] _____ cm</p> <p>[If Q13c="No"]</p> <p>Superior _____</p> <p>Anterior _____</p> <p>Right _____</p> <p>Inferior _____</p> <p>Posterior _____</p> <p>Left _____</p> <p>[If Q13a="Primary target"] [between 1 and 90]</p> <p>[If Q13a="Primary target"]</p> <p>[If Q13a="Pelvic nodes"]</p> <ul style="list-style-type: none"> • Simultaneous with primary target • Sequential plans
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<p>j. Was a uniform margin used for the NODAL PTV?</p> <p>k. Specify the uniform margin between the NODAL CTV structure and PTV structure in cm</p> <p>l. Specify the non-uniform margin between the NODAL CTV structure and PTV structure in cm:</p> <p>m. Dose delivered to the PELVIC NODES by this plan</p> <p>n. Number of fractions delivered to the PELVIC NODES by this plan</p> <p>o. Dose delivered to the SEMINAL VESICLES by this plan</p> <p>p. Number of fractions delivered to the SEMINAL VESICLES by this plan</p> <p>q. Dose delivered for the PROSTATE OR PROSTATE BED BOOST by this plan:</p> <p>r. Number of fractions delivered for the PROSTATE OR PROSTATE BED BOOST by this plan</p> <p>s. Dose delivered for the LN BOOST by this plan:</p>	<p>[If Q13a="Pelvic nodes"]</p> <ul style="list-style-type: none">• Yes• No <ul style="list-style-type: none">• Yes• No <p>[If Q13j="Yes"] _____ cm</p> <p>[If Q13j="No"]</p> <p>Superior _____</p> <p>Anterior _____</p> <p>Right _____</p> <p>Inferior _____</p> <p>Posterior _____</p> <p>Left _____</p> <p>[If Q13a="Pelvic nodes"] [between 1 and 90] _____ Gy</p> <p>[If Q13a="Pelvic nodes"]</p> <p>[If Q13a="Seminal vesicles"] [between 1 and 90] _____ Gy</p> <p>[If Q13a="Seminal vesicles"]</p> <p>[If Q13a="Focal boost of the prostate or prostate bed"] [between 1 and 90] _____ Gy</p> <p>[If Q13a="Focal boost of the prostate or prostate bed"]</p> <p>[If Q13a="Lymph node boost"] [between 1 and 90] _____ Gy</p>
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<p>t. Number of fractions delivered for the LN BOOST by this plan</p> <p>u. Enter the name of the target prescribed to by this plan</p> <p>v. Did the patient receive all of the planned dose?</p> <p>w. Planning type used to create this plan</p> <p>x. Delivery type of this plan</p>	<p>[If Q13a="Lymph node boost"]</p> <p>_____ [free text field]</p> <ul style="list-style-type: none"> • Yes • No • Forward planning • Inverse planning • 3D • IMRT • Rotational technique (VMAT or TomoTherapy) • Protons
<p>Treatment Delivery and Image Guidance</p>	
<p>What type of imaging was used to verify this patient's setup? Check all that apply.</p>	<ul style="list-style-type: none"> • kV/MV portal • CT (CBCT or TomoTherapy CT) • MR guidance directly before treatment • Ultrasound • Other. Please specify: _____
<p>For each imaging type, specify how often the patient was imaged during treatment.</p>	<p>[Provide drop-down menu for each response selected in Q14]</p> <ul style="list-style-type: none"> • Daily • Less than daily but more than weekly • Weekly • Other. Please specify: _____
<p>Was real-time guidance used during treatment?</p>	<ul style="list-style-type: none"> • Yes • No



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<p>What type of real-time guidance was used? Check all that apply.</p>	<p>[If Q16="Yes"]</p> <ul style="list-style-type: none">• Real-time kV tracking (such as based on fiducials)• MR guidance during treatment• Calypso radiofrequency system• Other. Please specify: _____
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