RECURRENCE / CONTRALATERAL DISEASE / METASTASIS CASE REPORT FORM

Patient ID: ______________________________ Date of Visit: ___________________________________

Check all that apply.

__Local Recurrence *(MammoSite Treated Breast)*

Date Recurrence First Detected: ___________________

Method of First Detection: *(Check one)* *__Mammogram __Physical Exam __ Ultrasound __MRI __ CT __Other:___________*

Date of First Biopsy: ______________________

Type of Biopsy: *__FNA __Core Needle __Lumpectomy __Other: _________________*

Exact Location of Local Recurrence: *__Tumor Bed*

***Breast**: __Left __Right*

***Quadrant:** __Upper __Lower __Midline __Outer __Inner __Midline*

Distance from Initial Tumor: ____________*mm*

Recurrence Tumor Size:

T

Tis: *__Pure DCIS __Padget's*

__T1a __T1b __T1c

__T2 __T3

__T4a __T4b __T4c __T4d

N *__Nx __N0 __N1 __N2 __N3*

M *__Mx __M0 __M1*

Pathological Diagnosis:

Histologic Type: (Check all that apply) __IDC __DCIS __Other_________________________

Histopathologic Grade: __Gx __G1 __G2 __G3 __G4 Other (Specify Grading System):___________________________

Tri-dimensional Size (Provide as much detail on size as available): _________ x _________ x _________

ER Status: _______________ *PR Status:* ________________ *HER-2 Status:* ___________________

Restaging Workup: __PET Scan __Bone Scan __CT __X-Ray __Blood Work __Other: ______________ __Not Done

Treatment of Local Recurrence: *(Check all that apply for this recurrence)*

__Lumpectomy Date: _____/_____/__________ __Mastectomy Date: _____/_____/________

__EBRT Date: _____/_____/__________ __PBI – MammoSite Date: _____/_____/__________

__PBI – 3D Date: _____/_____/__________ __PBI – Interstitial Date: _____/_____/__________

__Reconstruction Date: _____/_____/__________ __Observation

__Chemotherapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

__Hormonal Therapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

__Regional Recurrence

Date Recurrence First Detected: _____________________

Method of First Detection: *(Check one)* *__Mammogram _Physical Exam __Ultrasound __MRI __ CT __Other:___________*

Date of Biopsy: _______________________

Type of Biopsy: *__FNA __Core Needle __ALND __Other: _________________*

Exact Location of Local Recurrence: *__Axillary __Supraclavicular __Internal Mammary*

Pathological Diagnosis:

Histologic Type: _________________________

Histologic Grade: (Specify grading system) ____

Tri-dimensional Size (Provide as much detail on size as available): _________ x _________ x _________

Treatment of Regional Recurrence: *(Check all that apply for this recurrence)*

(*Specify)*____

__ Chemotherapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

__Hormonal Therapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

RECURRENCE / CONTRALATERAL DISEASE / METASTASIS CASE REPORT FORM

Patient ID: ______________________________ Date of Visit: ___________________________________

__Contralateral Disease

Date Disease First Detected: ______________

Method of First Detection: *(Check one)* *__Mammogram __Physical Exam __ Ultrasound __MRI __ CT __Other:_________*

Date of First Biopsy: ______________________

Type of Biopsy: *__FNA __Core Needle __Lumpectomy __Other: _________________*

Exact Location of Contralateral Disease: ***Breast**: __Left __Right* ***Quadrant:*** *__Upper __Lower __Midline* *__Outer __Inner __Midline*

Pathological Diagnosis:

Histologic Type: (Check all that apply) __IDC __DCIS __Other:_________________________

Histopathologic Grade: __Gx __G1 __G2 __G3 __G4 Other (Specify Grading System):__________________________

Tri-dimensional Size (Provide as much detail on size as available): _________ x _________ x _________

Treatment of Contralateral Disease: *(Check all that apply for the contralateral disease)*

__Lumpectomy Date: _____/_____/__________ __Mastectomy Date: _____/_____/__________

__EBRT Date: _____/_____/__________ __PBI – MammoSite Date: _____/_____/__________

__PBI – 3D Date: _____/_____/__________ __PBI – Interstitial Date: _____/_____/__________

__Reconstruction Date: _____/_____/__________ __Observation

__Chemotherapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

__Hormonal Therapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

__Distant Metastasis

Date Metastasis First Detected: ______________________

Method of First Detection: *(Specify)* __PET Scan __Bone Scan __CT __X-Ray __Blood Work __Other: ___________

Date of Biopsy: _______________________

Exact Location of Metastasis: (*List all Sites*) ____

Pathological Diagnosis:

Histologic Type: _________________________

Treatment of Distant Metastasis: *(Check all that apply for the metastasis)*

(*Specify)*____

_ Chemotherapy Type: __________________ Start Date: _____/______/________ Stop Date: _____/______/________

Copy of the pathology report provided for each recurrence reported? _Yes _No

Comments: ____

____ ______________________________

Signature Date