

IND Study # _____

Physical Exam

Pg of

Visit .

Subject ID: *

Visit Date:

Day

Month

Year

Subject Initials:

	WNL	ABN	√ if ND	Comment if Abnormal
General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Wall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pulmonary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lymphatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psych	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Completed by: _____

Date:

Day

Month

Year

IRB # _____

IND Study # _____

Tumor Assessment (COR)

Pg of

Visit .

Subject ID: *

Visit Date: Day

Month

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Subject Initials:

Target Lesion Measurement

Tumor laterality (check one) Left Right

Site

Horizontal . x Vertical .

Product (cm)
 .

√ if Not Applicable

. x .

.

Product of all target lesions .

Site codes: UOQ=Upper Outer Quadrant, LOQ=Lower Outer Quadrant, UIQ=Upper Inner Quadrant, LIQ=Lower Inner Quadrant, CEN=Centrally Located

Regional Nodes/Axilla

Does the subject have involvement of the regional nodes/axilla? Yes – complete below No

Site

Palpable?

Non-palpable?

Measurable?

Horizontal . x Vertical .

Product (cm)
 .

Product of all target lesions .

Site codes: RAX=Right Axilla, LAX=Left Axilla, RSC=Right Supraclavicular, LSC=Left Supraclavicular

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Vital Signs

Pg of

Visit .

Subject ID: # # * Visit Date:
Day Month Year

Subject Initials:

Date of this exam:
Day Month Year

Height: . cm In

Weight: . kg lbs

Blood Pressure: /

Pulse: / minute

Temperature: . °C °F

Respirations: / minute

Performance Status: 0 1 2

√ if Not Applicable

√ if Not Done

Post Treatment Time: :
H H M M

Blood Pressure: /

Pulse: / minute

Temperature: . °C °F

Respirations: / minute

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Laboratory

Pg of

Visit .

Subject ID: # *

Visit Date:

Day

Month

Year

Subject Initials:

Specimen Collection Date:

Day

Month

Year

WBC (K/ μ L)	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>	\sqrt if ND	Neutrophils (%)	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>	\sqrt if ND
Absolute Neutrophil Count	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>		Total bilirubin (mg/dL)	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>	
Platelets (K/ μ L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>		LDH (IU/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>	
RBC (M/ μ L)	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>		Alk. phos. (IU/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>	
Hemoglobin (g/dL)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>		SGOT/AST (IU/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>	
BUN (mg/dL)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>		SGPT/ALT (IU/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>	
Creatinine (mg/dL)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>		GGT (IU/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>	
Sodium (mEq/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>		PT (sec)	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>	
Potassium (mEq/L)	<input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>		PTT (sec)	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>	
CO ₂ (mEq/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>		INR	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/>	
Chloride (mEq/L)	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="text" value=""/>					

Assay Collection

_____ Day Month Year H H : M M

_____ Day Month Year H H : M M

Completed by: _____

On:

Day

Month

Year

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Urine Analysis

Pg of

Visit .

Subject ID: *

Visit Date:

Day

Month

Year

Subject Initials:

Specimen Collection Date:

Day

Month

Year

UPC

√ if
ND

Protein (mg/dL)

Creatinine (mg/dL) .

Protein / Creatinine ratio .

Urine Pregnancy Test

Date of Urine Pregnancy Test:

Day

Month

Year

or √ if NA

Completed by: _____

On:

Day

Month

Year

IRB # _____

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Drug Information

Pg of

Visit .

Subject ID: *

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Day

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Year

Subject Initials:

Study Drug Dosing Information

IND Drug (15mg/kg) mg

Day

Month

Year

Lot No.

Infusion Time:

Start Time :

Solution _____

90 ± Mins

Stop Time :

Reaction: Yes

60 ± Mins

No

30 ± Mins

Docetaxel (75mg/m²) mg

Day

Month

Year

Cyclophosphamide mg

Completed by: _____

On:

Day

Month

Year

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