

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 Year

Subject Initials:

Check here if tumor assessment was not performed

Target Lesion Measurement

Tumor laterality (check one) Left Right

Site		Horizontal	x	Vertical	Product (cm)
<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>		<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	x	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>
<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/> √ if Not Applicable	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	x	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>
Product of all target lesions					<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>

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)
<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> →	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	x	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>	<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>
Product of all target lesions							<input type="text" value=""/> <input type="text" value=""/> . <input type="text" value=""/>

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:

Check here if vital signs were not performed

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

\surd if Not Applicable

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

Assay Collection

_____ :

Day Month Year H H M M

_____ :

Day Month Year H H M M

Completed by: _____

On:
Day Month Year

IND Study # _____

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

Completed by: _____

On:

Day

Month

Year

IRB # _____

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Drug Information

Pg of

Visit .

Subject ID: *

Visit Date:

Day

Month

Year

Subject Initials:

Study Drug Dosing Information

Doxorubicin (60mg/m²)

mg

Day

Month

Year

Completed by: _____

On:

Day

Month

Year

IRB # _____