GUIDELINES FOR DESIGNING AND COMPLETING CASE REPORTS FORMS FOR PHASE I & II CHEMOPREVENTION TRIALS

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A. Introduction:

The purpose of this packet is to provide the Principal Investigator and data management staff with sample Case Report Forms (CRF) templates. These templates are for use with Phase I and II DCP chemoprevention trials. The templates contain recommended content and format and may be downloaded and modified with study specific information for each trial.
As indicated in the contract, a complete set of study specific Case Report Forms shall be submitted to the DCP PIO within 30 calendar days of the contract effective date for review and approval.

The following section "Guidelines for CRAs: Completing CRFs" is provided as educational information for staff who are responsible for completing these documents. The complete selection of template forms can be found following 'Section D' of this document.

B. Guidelines for CRAs: Completing the Case Report Forms

B1. General instructions for completing case report forms

B1.1 CRF may be completed by any assigned member of the study staff that has signed the Signature Form in the Clinical Trial Book.

B1.2 CRF should be completed within one week after the relevant information becomes available (*i.e.*, the subject completes the visit or the laboratory results have been received).

B1.3 Enter information on the CRF with an ink pen only.

B1.4 The information documented on the CRF **must be identical** to the information found in the primary source document (*i.e.*, subject charts, laboratory result printouts). NOTE: all source documents and CRFs must be available for verification by the NCI-designated CRA during routine monitoring and auditing visits.

B1.5 If the information is **missing**, enter "ND" (no data) in the boxes/space. If the information is **unknown**, write "UNK" in the boxes/space. Examples are as shown:

For missing: | *N* | *D* |

For unknown: | *U* | *N* | *K* |

Entries of 'Missing' or 'Unknown' information must be explained in the source document (*i.e.*, nurse's or clinic notes) for future verification.

B1.6 When boxes are provided for your response, please be sure to clearly mark the box you are choosing with a **T** or **V**. Make sure your mark is unambiguous.

B1.7 Corrections must be made in ink by crossing out the incorrect entry with a single horizontal line, placing the correct information next to the error, and providing an initial and date next to the correction. Do not backdate. **Do not** use any type of correction fluid or erase any entries on the forms.

B1.8 Do not write in the margins of the Case Report Forms. Any relevant additional information may be provided in the appropriate "comments" section.

B1.9 Avoid the use of abbreviations.

B1.10 CRFs are required for the following subjects:

- all subjects who received a procedure required by protocol after signing informed consent
- all subjects who have been randomized
- CRFs are not required for subjects screened and found to be ineligible

B2 Header/Identifier Information

B2.1 NCI Contract Number and Study Title: <u>Please place the NCI contract number and study title at the top of every form.</u>

B2.2 Version Date: Please print a version date on every form in the lower right corner. When changes are made to a form, update the form with a revision date.

B2.3 Subject Number: Each subject must be assigned a unique subject identification number. The number of spaces provided on the template should

accomodate your institution's numbering convention. This number is to be assigned after consent is obtained. Once a subject number has been assigned, it cannot be re-issued to another patient.

B2.4 Subject Initials: Please place the subject's first, middle and last initials in the boxes provided. Please be sure that this information is consistent on all CRFs.

Subject Initials: | T | S | T |
F M L

B2.5 Study Center Code (applies only to multicenter studies): Each center will be assigned a unique code. This entry will appear as follows in the header portion of every form:

Study Center Code: | 0 | 0 | 0 | 1 |

B2.6 Visit Number and Visit Date: Please place the visit number and the visit date in the spaces provided. Some visits, such as the baseline visit, may require multiple visit dates. All visit dates should be reflected on the case report form.

B3. Numeric Data Entry

B3.1 Date: Dates are recorded in MM-DD-YY format, where MM is the two-digit month (*i.e.*, enter 01 for January), DD is the two-digit day, and YY is the last two digits of the year. The date field appears on the CRF as follows:

| 0 | 4 | – | 0 | 1 | – | 9 | 8 |
Month Day Year

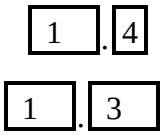
For incomplete dates, the month and year should be entered. Enter ND for the day. For example: | 0 | 4 | – | N | D | – | 9 | 8 |
Month Day Year

B3.2 Numbers: All numeric data should be right-justified. Do not use leading zeros for numeric data (except for Time and Date). Thus, the number "5" will appear as:

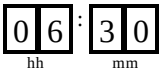
| | |

Numbers should be rounded to the nearest number of significant digits allotted for the entry. For example, the number "12.354" would appear as:

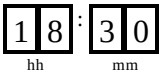
| 1 |



B3.3 Time: Time may be entered using the 24-hour clock or the 12-hour clock. Times are recorded in hh-mm format, where hh is the two-digit hour, and mm is the two-digit minute. Use leading zeros as necessary. For example in the 24-hour time clock 6:30 A.M. will be recorded as:



And 6:30 P.M. will be recorded as:



If using the 12-hour clock, add A.M. or P.M..

D. General Case Report Forms: Instructions for Design

C1 P.I. VERIFICATION FORM: The purpose of this form is to obtain Principal Investigator (PI) signature to verify the completion of the Case Report Forms following subject study completion or termination. This form should be signed by the PI only after all the CRFs for the subject are complete and verified by the PI. This form may be used in lieu of obtaining the PI signature on every case report form. The form may be used after each visit depending on the protocol and length of study.

C2 SUBJECT ENROLLMENT FORM**:** The purpose of this form is to gather demographic information at Baseline and to track milestone dates for each subject. The subject enrollment form should contain the following fields:

C2.1 Date of Birth**:** Dates must be complete and in compliance with the protocol eligibility criteria.

C2.2 Gender

C2.3 Race: If the race of the subject is not listed, mark **Other** and specify in the space provided. Please note: **Hispanic** includes Latino/Latina.

C2.4 Weight and Height: Circle either Lb or Kg and In or Cm. to indicate the unit of measure.

C2.5 Subject Number**:** One unique subject number will be assigned to each study subject. The subject number will remain the same throughout any subsequent phases of the study.

C2.6 Date Subject Enrolled: Date (MM/DD/YY) the subject signed the Informed Consent.

C2.7 Drug Start Date: Date the subject received first dose of study agent/placebo as part of actual intervention or run-in phase.

C.3 ELIGIBILITY FORM: This form is used at Baseline to document that the subject satisfies the inclusion and exclusion criteria for the study. The elements to be included on this form are:

C3.1 Inclusion Criteria: The criteria listed in this section must be identical to the inclusion criteria listed in the protocol. All answers to this section must be YES to admit the subject onto the study.

C3.2 Exclusion Criteria: The criteria listed in this section must be identical to the exclusion criteria listed in the protocol. All answers to this section must be NO to admit the subject onto the study.

C4 SUBJECT RANDOMIZATION FORM: This form is completed at baseline after the subject has satisfied all elements of the Eligibility Form. The form elements include:

C4.1 Date Run-in Started and Date Run-in Ended: Trial placebo treatment period before randomization to determine subject's compliance.

C4.2 Date Subject Randomized: Complete date required.

C4.3 Subject Randomization Code: Provide the subject randomization code/number in the space provided. If subjects are being stratified into specific cohorts add a field to capture the cohort code on this form.

C5. MEDICAL HISTORY: Complete this form at baseline to record the medical and surgical history of the subject.

C5.1 Check the 'Normal' box if the subject does not have a significant medical history and currently has no abnormality or condition in any of the Body Systems.

C5.2 For those Body Systems checked Abnormal, the condition(s) must be described in the Comments section.

C5.3 For additional conditions, please list under "Other," and specify the condition

C5.4 Record all procedures in the comment section under the appropriate Body System on this CRF. Include the name and date of the procedure/surgery.

C5.5 It is recommended that this evaluation be performed as close as possible to the first dose of study medication.

C6. PHYSICAL EXAMINATION: According to the specific directions in the protocol, this form may be required at Baseline, Monthly Visits, and/or Off Study. The purpose of this form is to document the results of the physical examination. The specific elements of this form are:

C6.1 Vital Signs: It is recommended that Respiration, Pulse and Blood Pressure be measured in the **supine** position.

C6.2 Performance Status: Use the perfomance status scale as specified by the protocol (ECOG, Zubrod, etc.)

C6.3 Body System**:** Check the 'Normal' box if the subject does not currently have an abnormality or condition in any of the Body Systems listed.

C6.4 For those Body Systems checked Abnormal, the condition(s) must be provided in the Comments section.

C7. CLINICAL LABORATORY DATA: The purpose of this form is to record clinical laboratory data performed prior to admission to the study and at intervals as specified by the protocol. According to the specific directions in

the protocol, this form may be required at Baseline, Monthly Visits, and/or Off Study.

C7.1 Modify the laboratory tests listed on the template form to reflect the specific requirements of the protocol.

C7.2 Insert the appropriate units, as per the laboratory normals.

C7.3 For multi-center studies, it is recommended that the parameters and units be consistent for all institutions performing labs.

C7.4 Comment on the clinical significance of all laboratory values outside the normal range.

C7.5 If the protocol requires repeat of laboratory tests with values outside the normal range, document the repeat testing result in the 'Comments' section.

C7.6 Note: a copy of the Laboratory Normal Ranges shall be provided to the NCI.

C7.7 If an abnormal laboratory result is considered "clinically significant," it must be recorded on the appropriate Adverse Event Case Report Form.

C7.8 Agent Levels: Any lab results which may potentially unblind the study (*i.e*. plasma drug/metabolite levels) shall not be entered until the final analysis is performed.

C7.9 Date of Collection**:** This date must reflect compliance with the protocol requirements.

C7.10 Fasting: Check this box if the specimen was obtained while the subject was fasting.

C8 COMPLIANCE: The purpose of this form is to document pill count or other methods to assess subject compliance and subject evaluability status. Complete this form at the intervals specified by the protocol (*i.e.,* monthly visits, off study). The recommended template elements include:

C8.1 The Compound Name, Dose(s), Units, Type (*i.e.*, capsules, liquid), Dispensing (amount dispensed per visit), Packaging (*i.e.*, how many

capsules or how much liquid per bottle) and Regimen will need to be modified to be specific to your protocol.

C8.2 Modify the boxes on the case report form to reflect the compliance methods required by the protocol. If more than one compliance method is used (*i.e.*, pill count and serum agent levels), both methods should appear on the compliance form. Please note: those methods (*i.e.*, serum agent levels) which may result in unblinding the study should be entered only after all subjects have completed the study.

C8.3 Affix the detached occluded portion of the study drug labels to the appropriate sections on this form. Keep the labels intact to preserve the blind. If more space is needed, it is recommended that a study drug label form be created.

C9 CONCOMITANT MEDICATION: The purpose of this form is to document all medications taken during the subject's treatment period. This cumulative form must be updated and entered at every visit and telephone contact.

C9.1 Enter the date of the visit in the boxes provided. This form can capture concomitant medication documentation for multiple visits.

C9.2 If a brand name was taken use that name of the medication. If a generic drug was taken use the generic name.

C9.3 Enter only one medication per section. If three medications are used for one indication, list all three medications individually in separate sections.

C9.4 At a minimum, the month and year of the Start and Stop Dates must be entered.

C9.5 Check the 'NONE' box only if the subject has not taken any concomitant medications throughout the duration of study. This box should be completed only after the subject completes or terminates the study.

C9.6 Medications administered for an Adverse Event (AE): Record the "Reason for Use" section exactly as it appears on the Adverse Event CRF.

C9.7 If this form is full prior to stopping a drug, check (**T**) the continuing box, and reenter the medication on another CRF exactly as it appears on the earlier CRF. However, do not check the continuing box on the new CRF until this form is full, or at the time of study completion.

C10 ADVERSE EVENTS: The purpose of this form is to document ALL adverse events experienced for the duration of the study including any run-in and follow-up periods. Update this form for every visit and telephone contact.

C10.1 Visit Dates**:** For each visit (*i.e.*, screen, baseline) enter the corresponding date into the boxes provided. This form can capture adverse event evaluations for multiple visits.

C10.2 The NONE box should be checked only if the subject has not experienced any adverse events throughout the study. This box should not be completed before the subject completes/terminates the study.

C10.3 Describe the Adverse Event as specifically as possible.

C10.4 Use only one line per event.

C10.5 All adverse events must be entered on this form, regardless of relationship to the study drug.

C10.6 Signs and Symptoms existing prior to study and documented on the Baseline Physical Examination CRF and on the Medical History CRF are not considered AEs. Only Baseline Signs and Symptoms that worsen while the subject is on the study drug are considered adverse events.

C10.7 Start and Stop Dates: Indicate month, date and year.

C10.8 Event Recovery Status: Indicate "Resolved" only if AE is resolved. If AE has not resolved even when subject goes off the study, indicate "Not Resolved."

C10.9 Continuing Adverse Events: If the AE continues and the subject is off the study, check the "Continuing" box.

C10.10 Relationship to Study Drug: This is the Principal Investigator's assessment of the relationship between the event and the study drug.

The relationship should be listed as not related, unlikely, possible, probable, or definite using the numbers provided.

C10.11 Toxicity Grade**:** Refer to the National Cancer Institute Common Toxicity Criteria, version 2.0.

C10.12 A **Serious Adverse Event (SAE)** is "any untoward medical occurrence that at any dose results in death, is life-threatening, requires subject hospitalization/prolongation of existing hospitalization, results in persistent or significant disability/incapacity, or is a congenital anomaly/birth defect. Important medical events that may not result in death, be life threatening, or require hospitalization may be considered SAE's, when, based upon appropriate medical judgement, they may jeopardize the subject and may require medical/surgical intervention to prevent one of the outcomes listed above.

All SAEs must be listed on the AE CRF. In addition, serious adverse events must be telephoned to the study monitor within 24 hours and a written report submitted within 48 hours of discovering the SAE.

C11 OFF STUDY FORM: The purpose of this form is to document subject completion, removal from, or drop-out from the study. The elements included in the template document are:

C11.1 Date On Follow-up and Date Off Follow-up: Protocol-specific evaluation period between the end of drug treatment and off study.

C11.2 Date Off Study: Date the subject completes the study or is no longer in the trial.

C11.3 Date Last Study Medication Taken**:** Provide the actual date the subject last took the study drug.

C11.4 Date of Last Contact: Date subject was last seen or spoken to. May be the same as the off study date.

C11.5 Reason Off Study: Check (**T**) only the main reason and provide explanations in the comment field.

C11.6 Any subject that is withdrawn for adverse events or pregnancy must be followed until resolution or until the Principal Investigator considers it unnecessary to continue follow up. Documentation of this follow-up must be maintained in the subject's study chart and on the "Continuing AE" section of the Off Study Form.

C12 DEATH REPORT FORM: The purpose of this form is to gather information regarding the subject's death if it occurred during run-in, treatment, or in follow-up.

C12.1 Any subject death is considered an adverse event and must be immediately reported to the NCI Medical Monitor.

C12.2 If the exact Date and Time are unknown, estimates are allowed.

D. Study-Specific Case Report Forms: Instructions for Design and Completion

D1 BIOMARKER FORMS: These study-specific forms are used to document the results of biomarker assays in studies with biomarker endpoints.

D1.1 The templates are designed to serve as a guide for development of study-specific biomarker Case Report Forms. A variety of sample forms are included in this document; however, forms for other types of biomarkers may need to be created specifically for your study. The following templates are included in this document:

Apoptotic Index
Cell Differentiation Biomarkers
Inflammatory Cytokines
DNA Ploidy Analysis
Inflammatory Cell Infiltrate
Intracrypt Apoptotic Index
Nuleolar Morphometry
PGE_2 Levels
Proliferation Analysis
Nuclear Morphometry

D1.2 Baseline biomarker results may be entered at the time the test is performed. However, subsequent results should not be documented until the subject has completed/terminated the study in order to maintain the blinding process.

D1.3 Biopsy Specimen Number, Slide Number and Tissue Section Number are identifiers. These may differ between laboratories and institutions. Identifiers are necessary to label the tissue samples in a blinded fashion.

D2 PHARMACOKINETICS FORMS: The purpose of these forms is to record serum agent levels for pharmacokinetics (PK) analyses in those studies with pharmacokinetic endpoints. Specific instructions for your consideration are:

D2.1 PK results should only be entered after subject is off study to maintain the blind.

D2.2 The sample amount and schedules should be modified to capture the specific requirements of each study.

D3 SCHEDULE OF FORMS: The purpose of this form is to create an "at-a-glance" guide that identify which forms are to be completed at various points within the study. The template may be modified to reflect the forms and time frames specific to an individual study.

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TEMPLATES FOR THE DESIGN OF CASE REPORT FORMS FOR PHASE I & II CHEMOPREVENTION PROTOCOLS

PIV

VERIFICATION FORM

NCI Contract Number: ☐☐☐☐☐☐☐☐☐☐ Study Title: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Subject Number: ☐☐☐ Subject Initials: ☐☐☐ (F M L) Date of Signature ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

The PI signature on this form should be obtained after ALL the Case Report Forms for this subject have been completed.

"I have reviewed all the Case Report Forms for the above subject and certify that they are accurate and complete."

Principal Investigator's Signature

Principal Investigator's Name (PLEASE PRINT)

ENR

SUBJECT ENROLLMENT FORM

NCI Contract Number: ☐☐☐☐☐☐☐☐ Study Title: ☐☐☐☐☐☐☐☐

Subject Number: ☐☐☐ Subject Initials: ☐☐☐ Visit: ☐ (F M L) Visit Date: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Subject Demographics

Subject Date of Birth: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Subject Weight: ☐☐☐ **Lb** or **Kg**

Gender: ☐ Male ☐ Female

Subject Height: ☐☐☐ **In** or **Cm**

Race: ☐ American Indian or Alaskan Native ☐ Asian or Pacific Islander

☐ Black, not of Hispanic Origin ☐ Hispanic

☐ White, not of Hispanic Origin ☐ Other: (specify)

Date Subject Enrolled: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Drug Start Date: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

ELIGIBILITY FORM

NCI Contract Number: ☐☐☐☐☐☐☐☐ Study Title: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Subject Number: ☐☐☐ Subject Initials: ☐☐☐ (F M L) Visit: ☐☐ Visit Date: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

INCLUSION CRITERIA: All answers to questions 1–8 must be **YES** for the subject to be eligible.

NO	YES		
☐	☐	1.	Is the subject over 18 years of age?
☐	☐	2.	Does the subject have an ECOG status of 0–2?
☐	☐	3.	Is the subject's WBC count $3,500 /FL?
☐	☐	4.	Is the subject's platelet count $100,000/FL?
☐	☐	5.	Is the subject's serum creatinine <1.6 mg/dl?
☐	☐	6.	Is the subject's serum bilirubin #1.6 mg/dl?
☐	☐	7.	If the subject is of child-bearing potential, does the subject have a negative pregnancy test (applies to female subjects only) and agree to use adequate contraception during and two months following the duration of this study (applies to both male and female subjects)?
☐	☐	8.	Has the subject been properly informed of the study and signed the Informed Consent?

Date Informed Consent signed: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Principal Investigator:_____

Date: _____

ELIGIBILITY FORM

NCI Contract Number: ☐ Study Title: ☐

Subject Number: ☐☐☐ Subject Initials: ☐☐☐ (F M L) Visit: ☐ Visit Date: ☐☐–☐☐–☐☐ (Month Day Year)

EXCLUSION CRITERIA: All answers to questions 9–13 must be **NO** for the subject to be eligible.

NO	YES		
☐	☐	9.	Does the subject have a history of heart disease?
☐	☐	10.	Has the subject received chemotherapy in the past 12 months?
☐	☐	11.	Is the subject's fasting cholesterol or triglycerides >300 mg/dl?
☐	☐	12.	Is the subject currently taking NSAIDs on a regular basis (*i.e.*, >3x/week)?
☐	☐	13.	Has the subject taken any investigational drug during the past 4 months?

Principal Investigator:____
Date:____

SUBJECT RANDOMIZATION FORM

NCI Contract Number: ☐☐☐☐☐☐☐☐ Study Title: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Subject Number: ☐☐☐ Subject Initials: ☐☐☐ (F M L) Visit: ☐☐ Visit Date: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Date Run-in Started: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Date Run-in Ended: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Date Subject Randomized: ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Subject Randomization Code: ☐☐☐☐

MEDICAL HISTORY

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Exam Date: (Month – Day – Year)

Examine the following and place a **T** in the appropriate column. If "Abnormal" is **T**'d then provide the condition(s) in the comments column as provided.

Body System	Normal	Abnormal	Not Done	Comments
Body as a Whole				
HEENT				
Cardiovascular				
Respiratory				
Gastrointestinal				
Genitourinary				
Musculoskeletal				
Neurological				
Endocrinological				
Dermatologic/Skin				
Hematologic/Lymphatic				

Principal Investigator:

_____

Date:_____

___

MEDICAL HISTORY

NCI Contract Number: ☐☐☐☐☐☐☐☐ Study Title: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Subject ID#: ☐☐☐ Subject Initials: ☐☐☐ (F M L) Visit ☐☐☐ Exam Date ☐☐ – ☐☐ – ☐☐ (Month – Day – Year)

Body System	Normal	Abnormal	Not Done	Comments
Metabolic/Nutritional				
Allergy/Drug Sensitivity				
Psychiatric				
Cancer				
Other, Specify				
Other, Specify				
Other, Specify				

Principal Investigator:

_____

Date:

_____

PHYSICAL EXAMINATION

NCI Contract Number: _____ Study Title: _____

Subject Number: ___ Subject Initials: ___ (F M L) Visit: _____ Exam Date: __ – __ – __ (Month – Day – Year)

VITAL SIGNS

Temperature: _____ . _____ EC/F(circle one)

Respiration Rate: _____ per min

Pulse: _____ bpm

Blood Pressure

Supine Measurements: _____ / _____ Systolic (mm Hg) Diastolic (mm Hg)

ECOG Performance Status: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Examine the following and place a **T** in the appropriate column. If "Abnormal" is **T**'d then provide the condition(s) in the comments column as provided.

Body System	Normal	Abnormal	Not Done	Comments
Appearance				
Skin				
HEENT				
Thyroid				
Chest				
Lungs				

Principal Investigator: _____

Date: _____

PHYSICAL EXAMINATION

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Exam Date: (Month – Day – Year)

Body System	Normal	Abnormal	Not Done	Comments
Breasts				
Heart				
Abdomen				
Musculoskeletal				
Genitalia				
Pelvic				
Rectal				
Prostate				
Vascular				
Neurological				
Lymph Nodes				
Other, Specify				

Principal Investigator:

_____

Date: _____

LAB1

CLINICAL LABORATORY DATA

NCI Contract Number: _____ Study Title: _____

Subject Number: ___ Subject Initials: ___ (F M L) Visit: _____ Visit Date: __ – __ – __ (Month – Day – Year)

Date of Collection: __ – __ – __ (Month – Day – Year) Fasting: ☐ Yes ☐ No

Please comment on any results that are out of normal range (*i.e.*, clinically significant, not clinically significant), and/or if repeat tests have been performed, in the comment column provided.

	Test		Results	Units	Comment
HEMATOLOGY	Hemoglobin		____.__		
	Hematocrit		____.__		
	RBC		____.__		
	WBC		____.__		
	DIFFERENTIAL	Neutrophils	____.__		
		Lymphocytes	____.__		
		Monocytes	____.__		
		Bands	____.__		
		Eosinophils	____.__		
		Basophils	____.__		
		Other	____.__		
	Platelet Count		____,___		

LAB2

CLINICAL LABORATORY DATA

NCI Contract Number: _____ Study Title: _____

Subject Number: ___ Subject Initials: ___ (F M L) Visit: _____ Visit Date: __ – __ – __ (Month – Day – Year)

	Test	Results	Units	Comment
BLOOD CHEMISTRY	Total Protein	____.__		
	Albumin	____.__		
	Ca^{+2}	____.__		
	PO_4	____.__		
	Cholesterol			
	Triglycerides			
	Glucose			
	Uric Acid	____.__		
	BUN			
	Creatinine	____.__		
	Total Bilirubin	____.__		
	Alk Phosphatase			
	Na^{+}			
	K^{+}	____.__		
	Cl^{-}			
	CO_2			
	AST (SGOT)			
	ALT (SGPT)			
	LDH			

CLINICAL LABORATORY DATA

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

	Test	Results	Units	Comment
URINE	Specific Gravity	.		
	pH			
	Protein			
	Glucose			
	Ketones			
	Blood			

	Parameter	Results	Units	Comment
OTHER	Pregnancy (HCG)			
	Serum Agent Levels *			
	Other Blood Levels *			

* To be completed at final analysis.

COMPLIANCE

NCI Contract Number: [ ] Study Title [ ]

Subject Number: [ ][ ][ ] Subject Initials: [ ][ ][ ] Visit: [ ] Visit Date: [ ][ ] – [ ][ ] – [ ][ ]

F M L Month Day Year

Compound Name: **AGENT**

Dispensing: **2 bottles per visit**

Dose: **200** Units: **mg**

Packaging: **60 capsules per bottle**

Type: **Capsules**

Regimen: **2 capsules qd**

Please be sure to collect the bottles at each visit and count the number of pills remaining.

Number of Bottles Returned: [ ]

Start Date of Drug for this Period: [ ][ ] – [ ][ ] – [ ][ ]
Month Day Year

Stop Date of Drug for this Period: [ ][ ] – [ ][ ] – [ ][ ]
Month Day Year

Number of Pills that Should Have Been Taken	Number of Pills Remaining in Both Bottles	Number of Pills Actually Taken	% of Pills Taken
[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]	[ ][ ][ ]

Comments (describe lost/missing/damaged pills):

AFFIX Label(s) from Study Medication below:

Label 1	Label 2

CONCOMITANT MEDICATIONS

NCI Contract Number: | | Study Title: | |

Subject Number: | | | Subject Initials: | | | (F M L)

~~Please enter visit date below~~:

Visit	Screen	Base-line	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6	Visit 7	Visit 8	Visit 9
Date											

Provide the following information for all medications including OTCs such as Aspirin, Tylenol, vitamins, laxatives**,** *etc*. If a medication is being used before the patient starts the study, write "PRETREATMENT" in the Start Date column. **Use Physician's Notes Form for comments.**

At end of study, check if none [ ]

Medication Name	**Dose/Schedule**	**Reason for Use**	**Start Date** MM/DD/YY	**Stop Date** MM/DD/YY	**Check if Continuing**

ADVERSE EVENTS

NCI Contract Number: | | Study Title: | |

Subject Number: | | | | Subject Initials: | | | | (F M L)

Please enter visit date below:

Visit	Screen	Base-line	Visit 1	Visit 2	Visit 3	Visit 4	Visit 5	Visit 6	Visit 7	Visit 8	Visit 9
Date											

At end of study check if none: [ ]

Use Physician's Notes Form for comments; if treatment required, also indicate drug and dose.

Adverse Event	**Start Date MM/DD/YY**	**Stop Date MM/DD/YY**	**Event Recovery Status (Resolved or Not Resolved)**	**TCheck if Continuing**	**Relationship to Study Drug 1 = Not related 2 = Unlikely 3 = Possible 4 = Probable 5 = Definite**	**Toxicity Grade (1-4 CTC Ver. 2)**	**TCheck if SAE**

OFF STUDY FORM

NCI Contract Number: ☐☐☐☐☐☐☐☐ Study Title: ☐☐☐☐☐☐☐☐

Subject Number: ☐☐☐ Subject Initials: ☐☐☐ (F M L) Visit: ☐☐☐☐☐☐ Visit Date: ☐☐-☐☐-☐☐ (Month Day Year)

Date on Follow-up: ☐☐–☐☐–☐☐ (Month Day Year) Date Off Follow-up: ☐☐–☐☐–☐☐ (Month Day Year)

Date Off Study: ☐☐–☐☐–☐☐ (Month Day Year) Date of Last Contact: ☐☐–☐☐–☐☐ (Month Day Year)

Date Last Study Medication Taken: ☐☐–☐☐–☐☐ (Month Day Year)

Reason Off Study (Please mark only the primary reason. Reasons other than Completed Study require explanation in Comments section below)

- ☐ Completed Study
- ☐ Adverse Event (complete AE CRF). Please list event(s) in comment section
- ☐ Lost to Follow-up
- ☐ Death (complete Death Report CRF)
- ☐ Other (please specify in Comments section)

Comments:

Continuing Adverse Event

Adverse Event: _____

Start Date of Event: _____

Outcome: _____

DR

DEATH REPORT FORM

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

All concomitant medications taken up to the time of death should be listed on the Concomitant Medications form. If an autopsy was performed, please send a copy of the report to NCI, DCP as soon as it is available.

Date of Death: (Month – Day – Year)

Place of Death:

- ☐ Hospital (attach discharge summary)
- ☐ Other

Autopsy performed? ☐ NO ☐ YES (attach autopsy report or send to NCI, DCP when available)

Cause of Death:

- ☐ Study Treatment
- ☐ Other, please specify:

Comments:

APOPTOTIC INDEX

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Total Number of Sections/Specimen:

Tissue Section Number	
Total Number of Apoptotic Cells	
Total Number of Cells Counted	
Apoptotic Index	

CELL DIFFERENTIATION BIOMARKERS

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Tissue Section Number:

	Cytokeratin	**Lectin SBA**	**Sialylated Le^X**	**B72.3**
Total Number of Crypts Measured				
Total Area of Crypts Measured (mm^3)	mm^3	mm^3	mm^3	mm^3
Total Area of Positive Labeling (mm^3)	mm^3	mm^3	mm^3	mm^3
Percent Positive Cells (Number of Positive Cells/Number of Cells Counted)	%	%	%	%
Mean OD of Labeled Cells				

INFLAMMATORY CYTOKINES

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Cytokine	Cytokine/â-Actin
IL-1	
IL-6	
TNF-á	
KGF	

DNA PLOIDY ANALYSIS

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Tissue Section Number	Summed Optical Density (OD)
Mean Optical Density =	

Total Number of Sections Counted:

INFLAMMATORY CELL INFILTRATE

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Antigen	Number of Cells/mm^3
CD3 Antigen	
CD4 Antigen	
CD8 Antigen	
CD20 Antigen	
CD16, CD56, CD57 Antigens	
CD11b, CD14, CD68 Antigens	
HML-1	
MHC Class I	
MHC Class II	

Total Number of Sections Counted:

INTRACRYPT APOPTOTIC INDEX

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Total Number of Sections / Specimen:

Section Number	
Total Number of Crypts	
Total Number of Apoptotic Cells per Crypt	
Total Number of Cells Counted per Crypt	
Apoptotic Index	

NUCLEOLAR MORPHOMETRY

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Tissue Section Number	Number of Nucleoli/Cell	Nucleolar Area (Cell)	Nucleolar Shape (ratio of minimum diameter to maximum diameter)	Position of Nucleoli (µm) (mean distance from membrane)
	Mean Number of Nucleoli/Cell:	Mean Nucleolar Area (Cell):		

Total Number of Sections per Specimen:

PGE_2 LEVELS

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

PGE_2 Level	Protein Concentration	Normalized PGE_2 (pg/µg protein)

PROLIFERATION ANALYSIS

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Tissue Section Number:

	BrdU Immunohistochemistry	PCNA Immunohistochemistry
Total Number of Crypt Columns Assayed		
Total Number of Cells		
Total Number of Labeled Cells		
Position of Labeled Cells (positive cells counted for each third)	Upper Third Middle Third Lower Third	Upper Third Middle Third Lower Third
Total Number of Cells per Compartment	Total Number of Cells Number of Labeled Cells per Compartment: Compartment 1 (base) Compartment 2 Compartment 3 Compartment 4 Compartment 5 (surface)	Total Number of Cells Number of Labeled Cells per Compartment: Compartment 1 (base) Compartment 2 Compartment 3 Compartment 4 Compartment 5 (surface)
Total Number of Cells/Crypt		
Labeling Index (total labeled cells/total cells counted)		

PROLIFERATION ANALYSIS

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

	BrdU Immunohistochemistry	PCNA Immunohistochemistry
Proliferation Zone	Upper Third	Upper Third
	Middle Third	Middle Third
	Lower Third	Lower Third
Mean OD of Labeled Cells		

NUCLEAR MORPHOMETRY

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Biopsy Specimen Number:

Slide Number:

Tissue Section Number	Morphometric Z-Score
Mean Z-Score =	

Total Number of Sections Counted:

PK

PHARMACOKINETICS FORM

NCI Contract Number: Study Title:

Subject Number: Subject Initials: (F M L) Visit: Visit Date: (Month – Day – Year)

Last Dose given at: (hh : mm) Sample Amount: **3 ml**

In order to maintain the blind, test results must be entered only after the subject has completed the study.

Sample No.	Scheduled Time	Scheduled Clock Time	Actual Time	Results*
1	Prior to drug start	hh : mm	hh : mm	
2	0 hour	hh : mm	hh : mm	
3	1 hour	hh : mm	hh : mm	
4	2 hour	hh : mm	hh : mm	
5	4 hour	hh : mm	hh : mm	
6	8 hour	hh : mm	hh : mm	
7	24 hour	hh : mm	hh : mm	
				*To be completed after subject termination

Schedule of Forms Template

The schedule of forms is based upon the procedures listed in the protocol. A Case Report Form should be completed for each X, unless otherwise indicated.

Form	Baseline Visit	Month 1 Visit	Month 2 Visit	Termination Visit	Follow-Up
P.I. Verification Form					X[1]
Subject Enrollment Form	X				
Eligibility Form	X				
Subject Randomization Form	X				
Medical History	X				
Physical Examination	X	X	X	X	
Clinical Laboratory Data	X	X	X	X	
Compliance		X	X	X	
Concomitant Medications	X	X	X	X	X
Adverse Events		X	X	X	X
Termination Form				X	
Death Report Form[2]				X	
Biomarker Forms	X	X	X	X	
Pharmacokinetic Forms	X			X	

[1]The PI Verification Form should be signed after all the Case Report Forms have been completed.

[2]The Death Report Form is completed only after a subject has died while on study, or in follow-up.