NATIONAL CENTRE FOR DISEASE INFORMATICS AND RESEARCH
NATIONAL CANCER REGISTRY PROGRAMME

Indian Council of Medical Research

PATTERNS OF CARE AND SURVIVAL STUDIES

Patient Information Form - Cancer Cervix

A. IDENTIFYING, DEMOGRAPHIC AND DIAGNOSTIC INFORMATION

1. Name of Participating Centre ..... Centre Code | | | |

2. Registration Number *(as in HBCR)*
(First 2 digits are for year of registration and the next 5 digits for actual registration number) | | | | | | | |
Year *Reg. No.*

3.1 (a) Name of Source of Registration ..... Code | | | |
(Reporting Institution (RI) / Hospital)

(b) Name of Department / Unit etc. ..... Code | | | |

(c) Name of Physician ..... Mobile No.....

3.2 Hospital Registration Number .....

3.3 Date of Registration at Source of Registration /
Date of Reporting at this Hospital | | | | | | |
dd *mm* *yy*

3.4 Case Registered As

(1) Out-patient (OP) ☐ (2) In-patient (IP) ☐
(3) OP and IP ☐ (4) Not Registered - Clinical Consultation / Opinion ☐
(5) Not Registered - Pathology Consultation / Opinion ☐ (8) Others *(specify)*..... ☐

4. Date of First Diagnosis
(Date of first attendance to any hospital for this disease) | | | | | | |
dd *mm* *yy*

5. Full Name of Patient ....
(At least one name is compulsory) *First* *Second* *Last*

6. Name of Spouse / Father / Mother / Caretaker *(give any two names)*

....
Name *Mobile No.* *Name* *Mobile No.*

7. Place of Residence: Permanent place of residence *(where the person has been residing for the past one year (at least))*

Urban Areas *(Town / city / any other)*

House No.....

Road / Street Name.....

Area / Locality.....

Ward / Corporation / Division | | |

Name of City / Town .....

Non-urban / Rural Areas

House No. and Ward .....

Name of Gram Panchayat / Village, etc:

.....

Name of Sub-Unit of District *(Taluk / Tehsil / Other):*

.....

Name of PHC / Sub Centre .....

Name of District *(in capitals)* ..... Postal Pin Code | | | | | | |

Telephone No(s).: Off. ..... Res. .....

Mobile No. ..... Email ID .....

Aadhaar *(Unique Identification)* No. .....

8. Duration of Stay *(at the permanent place of residence (in years))*

9.1 Local Address

.....

.....

Name of City/Town/District .....

Pin Code

9.2 Name & Address of Referring / Family Doctor

.....

.....

Name of City/Town/District.....

Pin Code

10. Age *(in years)*

Date of Birth *dd mm yy*

11. Sex - Female

12. Method of Diagnosis

(1) Clinical Only (2) Microscopic (3) X-Ray / Imaging Techniques

(8) Others (9) Unknown

Microscopic *(if 2 above)*

(1) Histology of Primary
(2) Histology of Metastasis
(3) Cytology of Primary
(4) Cytology of Metastasis

X-Ray / Imaging Techniques *(if 3 above)*

(1) X-Ray
(2) Isotopes
(3) Angiography
(4) Ultrasonogram
(8) All Others *(specify)*.....

Others *(if 8 above)*

(1) Surgery or Autopsy without Histology
(2) Specific Biochemical and / or Immunological Tests
(8) Others *(specify)*.....

13. Anatomical Site of Specimen / Biopsy / Smear.....

14. Complete Pathological Diagnosis: *(With complete description of Primary Site of Tumour and Morphological Diagnosis)*

14.1 Primary Site of Tumour - Topography.....

14.2 Morphology.....

14.3 Pathology Slide No. Date *dd mm yy*

15. Coding According to ICD-O-3:

15.1 Primary Site of Tumour - Topography ..... C .
(Include sub-site if any)

15.2 Primary Histology - Morphology ..... M / /
If morphology is that of metastasis mention Primary Site above and

15.3 Secondary Site of Tumour..... C .

15.4 Morphology of Metastasis ..... M / /
If the morphology diagnosis is only that of metastatic site, mention the Primary Site as decided by the treating clinician either through discussion or from case record.

16. Sequence

(0) One Primary Only
(1) First of two or more primaries
(2) Second of two or more primaries
(3) Third of three or more primaries
(4) Fourth of four or more primaries
(5) Fifth of five or more primaries
(6) Sixth of six or more primaries
(7) Seventh of seven or more primaries
(8) Eighth or later primary
(9) Unspecified sequence number *(Unknown)*

B. DETAILS OF SOCIOECONOMIC STATUS, FAMILY INCOME, OCCUPATION, ETC.

_____

_____

_____

Co-Morbid Conditions	*Yes*	*No*	*Unknown*	*Co-Morbid Conditions*	*Yes*	*No*	*Unknown*
(1) Tuberculosis	☐	☐	☐	(2) Hypertension	☐	☐	☐
(3) Diabetes	☐	☐	☐	(4) Ischaemic Heart Disease	☐	☐	☐
(5) Bronchial Asthma	☐	☐	☐	(6) Allergic Conditions *(specify)*.....	☐	☐	☐
(7) Hepatitis / HBsAg +ve	☐	☐	☐	(8) Others *(specify)*.....	☐	☐	☐
(10) AIDS/HIV +ve	☐	☐	☐				

C. DETAILS OF STAGE *(Tick (√) as appropriate)*

1. Staging System Followed

(1) FIGO staging ☐ (2) TNM staging ☐ (8) Others *(specify)*..... ☐ (9) Unknown ☐

2. Staging done at

(1) Reporting Institution ☐ (2) Previous Institution ☐ (8) Others *(specify)*..... ☐ (9) Unknown ☐

3. Stage

I ☐	IA ☐	IA1 ☐	IA2 ☐	
	IB ☐	IB1 ☐	IB2 ☐	
II ☐	IIA ☐	IIA1 ☐	IIA2 ☐	IIB ☐
III ☐	IIIA ☐	IIIB ☐		
IV ☐	IVA ☐	IVB ☐	Unknown ☐	

If TNM *specify*..... ☐☐☐☐ T ☐☐ N ☐☐ M

4. Investigations for Staging

	Yes	No	Unknown		Yes	No	Unknown
(1) Haemogram	☐	☐	☐	(2) Biochemistry	☐	☐	☐
(3) Chest X-ray	☐	☐	☐	(4) Examination under Anaesthesia	☐	☐	☐
(5) Cystoscopy	☐	☐	☐	(6) Ultrasound of abdomen & pelvis	☐	☐	☐
(7) Proctosigmoidoscopy	☐	☐	☐	(8) Others *(specify)*.....	☐	☐	☐
(10) CT Scan	☐	☐	☐	(11) MRI	☐	☐	☐

Specify any relevant abnormal findings _____

_____

5. The actual assessment of staging was done by

(1) One Consultant Oncologist (CO) only ☐ (2) Two COs from same department ☐

(3) Two COs from different departments ☐ (4) Tumour Board/Joint Clinic ☐

(8) Others *(specify)*..... ☐ (9) Unknown ☐

D. DETAILS OF CANCER DIRECTED TREATMENT (CDT) *(Tick (✓) as appropriate)*

6. Treatment given prior to Registration at Reporting Institution (RI)

(0) No ☐ (2) Yes ☐ (9) Unknown ☐

If yes,

6.1 Type of Prior Treatment Given:

		Yes	No	Unknown	If yes, Date of completion of treatment (dd mm yy)
(1)	Surgery	☐	☐	☐	
(2)	Radiotherapy	☐	☐	☐	
(3)	Chemotherapy	☐	☐	☐	
(8)	Others *(specify)*.....	☐	☐	☐	

6.2 Details of Prior Treatment *(including treatment interruption and complications)* _____

_____

7. Treatment at Reporting Institution

7.1 Intention to Treat

(1) Curative/Radical ☐ (2) Palliative ☐

(3) No treatment ☐ (9) Unknown ☐

7.2 If Palliative yes,

(1) Palliative RT only ☐ (2) Palliative RT + CT ☐ (3) Palliative CT only ☐

(4) Pain & Symptom Relief Drugs *(specify)*..... ☐ (5) Palliative Surgery ☐

(8) Others *(specify)*..... ☐ (9) Unknown ☐

7.3 Type of Cancer Directed Treatment Planned at Reporting Institution:

		Yes	No	Unknown
(1)	Surgery	☐	☐	☐
(2)	Radiotherapy	☐	☐	☐
(3)	Chemotherapy	☐	☐	☐
(8)	Others *(specify)*.....	☐	☐	☐

8. Performance Status (WHO) before treatment

(0) Able to carry out all normal activity without restriction ☐

(1) Restricted in physically strenuous activity but ambulatory and able to carry out light work ☐

(2) Ambulatory and capable of all self-care but unable to carry out any work; up and about more than 50% of waking hours ☐

(3) Capable of only limited self-care; confined to bed or chair more than 50% of waking hours ☐

(4) Completely disabled; cannot carry on any self-care; totally confined to bed or chair ☐

(9) Unknown ☐

9. Surgery

9.1
- (0) Surgery not planned ☐
- (1) Yes, done as planned/advised ☐
- (2) Surgery planned but not taken ☐
- (8) Others *(specify)*..... ☐
- (9) Unknown ☐

9. 2 If yes, Type of Surgical Procedure
- (1) Total (extra-fascial) Abdominal Hysterectomy (Type I) ☐
- (2) Modified Radical Hysterectomy (Type II) ☐
- (3) Radical Abdominal Hysterectomy (Type III) ☐
- (4) Extended Radical Hysterectomy (Type IV) ☐
- (5) Pelvic Excenteration ☐
- (8) Others *(specify)*..... ☐
- (9) Unknown ☐

9.3 If yes, Lymphadenectoy (1) Not Done ☐ (2) Done ☐

9.4 Date of Surgical Procedure ☐☐ *dd* ☐☐ *mm* ☐☐ *yy*

10. Surgical Histopathological Findings

10.1 Size of Tumour in Cervix
- (0) NA* ☐
- (1) No Viable tumor ☐
- (2) Tumor present (Size NK) ☐
- (3) Tumor < 2 cm ☐
- (4) Tumor 2 - 4 cm ☐
- (5) Tumor 4 - 6 cm ☐
- (6) Tumor > 6 cm ☐
- (9) NK** ☐

10.2 Thickness of Cervical Invasion
- (0) NA ☐
- (1) < 1/3 / in-situ ☐
- (2) < 1/2 ☐
- (3) = 2/3 ☐
- (4) Full thickness ☐
- (9) NK ☐

10.3 Involvement of Uterus
- (0) NA ☐
- (1) Not involved ☐
- (2) Involved ☐
- (3) Endocervix extn. ☐
- (9) NK ☐

10.4 Thickness of Uterine Invasion
- (0) NA ☐
- (1) Endometrium ☐
- (2) Myometrium ☐
- (3) Serosa + ve ☐
- (9) NK ☐

** Not Applicable, ** Not Known*

10.5 Involvement of Vagina *(Cut edges)*

(0) NA ☐ (1) Negative ☐ (2) Positive ☐

(3) Edge Close / +ve ☐ (9) NK ☐

10.6 Involvement of Parametrium

(0) NA ☐ (1) Negative ☐ (2) Positive ☐ (9) NK ☐

10.7 Tumor Emboli

(0) NA ☐ (1) No ☐ (2) Yes ☐ (9) NK ☐

10.8 Involvement of Ovaries

(0) NA ☐ (1) Not involved ☐ (2) Involved ☐ (9) NK ☐

10.9 Involvement of Regional Nodes

(0) NA ☐ (1) Not involved ☐ (2) Involved (Metastatic) ☐ (9) NK ☐

10.10 Site of Involved Regional Nodes

(0) NA ☐ (1) Not involved ☐ (2) Ilio- obtur. ☐

(3) Iliac node ☐ (4) Obturator ☐ (5) Pre- Sacral ☐

(6) Paracervical ☐ (7) Parametrial ☐ (9) NK ☐

10.11 Para-aortic Node(s)

(0) NA ☐ (1) Not involved ☐ (2) Involved (Metastatic) ☐ (9) NK ☐

10.12 Laterality of Positive Nodes

(0) NA ☐ (1) Not involved ☐

(2) Unilateral (R / L) ☐ (3) Bilateral ☐ (9) NK ☐

10.13 No. of Positive Nodes

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ >4 ☐ NK ☐

10.14 Tumour Grade

(0) NA ☐ (1) Grade I ☐ (2) Grade II ☐

(3) Grade III ☐ (4) Grade IV ☐ (9) NK ☐

10.15 Lymphovascular Space Involvement

(0) NA ☐ (1) Not involved ☐ (2) Involved ☐ (9) NK ☐

11. Radiotherapy

11.1 (0) Radiotherapy (RT) not planned ☐ (1) Yes, RT given as planned ☐

(2) Yes, RT given, but incomplete ☐ (3) RT planned but not taken ☐

(specify reason)..... *(specify reason)*.....

(8) Others *(specify)*..... ☐ (9) Unknown ☐

11.2 Type of RT

(1) Teletherapy (External RT) ☐ (2) Brachytherapy ☐ (3) 3D Conformal ☐

(4) IMRT ☐ (5) Electron Beam ☐

(8) Others *(specify)*..... ☐ (9) Unknown ☐

11.3 Details of External RT	I	II	III
Technique *(specify)*	.....	.....	.....
Type of beam *(Photon/Electron)*	.....	.....	.....
Energy	.....	.....	.....
Field Size	.....	.....	.....
Field/day	.....	.....	.....
Total Tumour Dose (cGy)	.....	.....	.....
Total No. of Fractions	.....	.....	.....
Fractions / week	.....	.....	.....
Region(s) of Irradiation	.....	.....	.....
Interruption - YES (Y) / NO (N)	.....	.....	.....
Date first started			
Date last ended	*dd mm yy*	*dd mm yy*	*dd mm yy*

11.4 Details of Brachytherapy

	I	II	III	IV	V	>V
Date	dd mm yy	dd mm yy	dd mm yy	dd mm yy	dd mm yy	dd mm yy
Type of applicators	.....	.....	.....	.....	.....	.....
Type of Dose Rate *(LDR/MDR/HDR/PDR)*	.....	.....	.....	.....	.....	.....
Dose in cGy. to point A/ ICRU Reference Points/ Any other *specify*....	.....	.....	.....	.....	.....	.....
Dose rate in cGy.	.....	.....	.....	.....	.....	.....
Dose to Rectum in cGy.	.....	.....	.....	.....	.....	.....
Dose to Bladder in cGy.	.....	.....	.....	.....	.....	.....

12. Chemotherapy

12.1

- (0) Chemotherapy (CT) not planned ☐
- (1) Yes, CT given as planned ☐
- (2) Yes, CT given, but incomplete ☐
- (3) CT planned but not taken ☐
- (8) Others *(specify)*..... ☐
- (9) Unknown ☐

If Yes,

12.2 Type of CT

- (1) Anterior/neo-adjuvant/induction ☐
- (2) Concurrent ☐
- (3) Adjuvant ☐
- (4) Combination of any of the above ☐
- (8) Others *(specify)*..... ☐
- (9) Unknown ☐

12.3 Drug(s) comprising CT Regimen

- (1) Single *(specify)*..... ☐
- (2) Two Drug *(specify)*..... ☐
- (3) More than two drug *(specify)*..... ☐
- (8) Others *(specify)*..... ☐
- (9) Unknown ☐

12.4 Other Details of CT

Height in cms. ☐☐☐ Weight in Kg. ☐☐

Cycles	I	II	III	IV	V	VI	>VI
Regimen	_____	_____	_____	_____	_____	_____	_____
Date(s)	☐☐☐ dd mm yy	☐☐☐ dd mm yy	☐☐☐ dd mm yy	☐☐☐ dd mm yy	☐☐☐ dd mm yy	☐☐☐ dd mm yy	☐☐☐ dd mm yy
Day(s)	_____	_____	_____	_____	_____	_____	_____

Drug (s)

Name	Dose	Dose	Dose	Dose	Dose	Dose	Dose
.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....
.....	.....	.....	.....	.....	.....	.....	.....

Date of start of First Cycle of CT ☐☐☐ *dd mm yy*

Date of completion of Last Cycle of CT ☐☐☐ *dd mm yy*

13. Response of Disease (Adopted from WHO) to RT / RT + CT *(6-12 weeks after completion of treatment)*

(0) RT / CT not received ☐

(1) Complete response - No Evidence of Disease ☐

(2) Partial response ☐

(3) No change ☐

(4) Progressive disease ☐

(5) Post Surgical - Adjuvant ☐

(9) Unknown ☐

13.1 Date(s) of assessment of response to RT / RT + CT ☐☐☐ *dd mm yy* ☐☐☐ *dd mm yy*

14.1 Date of Completion of Initial Cancer Directed Treatment at RI

dd mm yy

14.2 Complications During Treatment

(0) No ☐ (2) Yes ☐ (9) Unknown ☐

If Yes,

Nature of Complication(s)	Maximum Grade	Date of Onset	Resolved Yes	Resolved No	Date last seen (if resolved)
_____	_____	☐☐☐	☐	☐	☐☐☐
_____	_____	☐☐☐	☐	☐	☐☐☐
_____	_____	☐☐☐	☐	☐	☐☐☐
_____	_____	☐☐☐	☐	☐	☐☐☐
_____	_____	☐☐☐	☐	☐	☐☐☐
_____	_____	☐☐☐ (dd mm yy)	☐	☐	☐☐☐ (dd mm yy)

15. Performance Status at 6-12 Weeks of Completion of all of CDT

(0) Able to carry out all normal activity without restriction ☐

(1) Restricted in physically strenuous activity but ambulatory and able to carry out light work ☐

(2) Ambulatory and capable of all self-care but unable to carry out any work; up and about more than 50% of waking hours ☐

(3) Capable of only limited self-care; confined to bed or chair more than 50% of waking hours ☐

(4) Completely disabled; cannot carry on any self-care; totally confined to bed or chair ☐

(9) Unknown ☐

15.1 Date of Assessment of Performance Status

dd mm yy

E. FOLLOW-UP INFORMATION *(USE SEPARATE PAGE FOR EACH VISIT)*

16. Due Date for Follow up dd mm yy

Date of Actual Follow-up dd mm yy

Follow-up Visit No.

16.1 Method of Follow-up

(0) No follow-up ☐ (1) Hospital visit ☐ (2) By post ☐

(3) Through telephone ☐ (4) Home visit ☐ (8) Others *(specify)*..... ☐

(9) Unknown ☐

16.2 Vital Status

(1) Alive ☐ (2) Dead ☐ (9) Unknown ☐

16.3 Disease Status *(at Follow-up)*

(1) No Evidence of Disease ☐ (2) Residual Disease only ☐

(3) Local recurrence ☐ (4) Regional/Nodal recurrence ☐

(5) Distant metastasis : *specify site*..... ☐ (9) Unknown ☐

16.4 If Disease is present, indicate Basis of Diagnosis

(1) Histopathology ☐ (2) Cytopathology *(Other than FNAC)* ☐ (3) FNAC ☐

(4) Bone Marrow ☐ (5) Peripheral Smear ☐ (6) Radiological ☐

(7) Clinical ☐ (8) Others *(specify)*..... ☐ (9) Unknown ☐

16.5 Treatment if 16.3 above indicates presence of disease

(0) No Treatment ☐ (2) Yes, Treatment given ☐ (9) Unknown ☐

16.6 If yes, Details of Treatment and Outcome *(Use separate sheet if necessary)*

_____

_____

16.7 Late Complications of CDT

(0) Nil ☐ (2) Yes ☐ (9) Unknown ☐

If Yes,

Nature of Complication(s)	Maximum Grade	Date of Onset	Resolved Yes	Resolved No	Date last seen *(if resolved)*
		dd mm yy			dd mm yy

■ = *Mandatory;* ■ = *Recommended;* ■ = *Optional*

17. Second Primary

(0) No evidence of second primary ☐ (2) Yes, evidence of second primary ☐ (9) Unknown ☐

If Yes,

17.1 Primary Site of Tumour (ICD-O-3) (Topography) C ☐☐•☐

17.2 Primary Histology (ICD-O-3) (Morphology) M ☐☐☐☐/☐/☐

17.3 Secondary (Metastatic) Site of Tumour (ICD-O-3) C ☐☐•☐

17.4 Histology of Metastasis M ☐☐☐☐/☐/☐

17.5 Method of Diagnosis

(1) Clinical Only ☐ (2) Microscopic ☐ (3) X-Ray / Imaging Techniques ☐ (8) Others ☐ (9) Unknown ☐

Microscopic *(If 2 above)*		X-Ray / Imaging Techniques *(If 3 above)*		Others *(If 8 above)*	
(1) Histology of Primary	☐	(1) X-Ray	☐	(1) Endoscopy	☐
(2) Histology of Metastasis	☐	(2) Isotopes	☐	(2) Surgery or Autopsy without Histology	☐
(3) Autopsy with Histology	☐	(3) Angiography	☐	(3) Specific Biochemical and /	
(4) Bone Marrow	☐	(4) Ultrasonogram	☐	or Immunological Tests	☐
(5) Blood Film	☐	(8) All Others *(specify)*.....	☐	(8) Others *(specify)*.....	☐
(6) Cytology of Primary	☐				
(7) Cytology of Metastasis	☐				

17.6 Date of Diagnosis ☐☐ ☐☐ ☐☐ *dd mm yy*

17.7 Details of Treatment and Outcome: *Use separate appropriate form.*

18. If Dead,

18.1 Cause of Death

(1) As a result of cancer ☐ (2) Most probably due to cancer ☐ (3) Intercurrent Death ☐

(4) Treatment related Death ☐ (8) Others *(specify)*..... ☐ (9) Unknown ☐

18.2 Date of Death ☐☐ ☐☐ ☐☐ *dd mm yy*

19. Remarks *(add additional sheet(s) if necessary)*