Patient with Cancer Predisposition Syndrome (CPS)

Patient initials (first name, last name) |__|__|

Quarter and Year of Birth (q/yyyy) |__|/|__|__|__|__|

Sex □ male □ female

Survival status:

☐ Alive Date of last examination I__I__II__I__II__I__I Karnofsky/Lansky score I_____I %

☐ Dead Date of death I__I__II__I__II__I__I Autopsy ☐ no ☐yes

Main cause of death: Please specify |_____|

Malignancy

Diagnosis of malignancy since last follow-up:

☐ No

☐ Yes specify (histology/site) |_____|

Date of malignancy diagnosis I__I__II__I__II__I__I

Chemotherapy ☐ Yes ☐ No

Radiation ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Comment: |_____|

☐ Yes specify (histology/site) |_____|

Date of malignancy diagnosis I__I__II__I__II__I__I

Chemotherapy ☐ Yes ☐ No

Radiation ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Comment: |_____|

Please submit copies of

- **Clinic notes summarizing the diagnosis of malignancy**
- **Pathology reports**
- **(cyto)genetic characterization**

Surveillance

Surveillance:

□ No

□ Yes, according to the AACR surveillance recommendations for patients with

- □ Leukemia-Predisposing Conditions
- □ DNA Repair Disorders
- □ Inherited Mismatch Repair Deficiency
- □ Li-Fraumeni Syndrome
- □ Neurofibromatosis 1
- □ Neurofibromatosis 2 and Related Disorders
- □ Rhabdoid Tumor Predisposition Syndrome
- □ Von Hippel-Lindau and Hereditary Pheochromocytoma/Paraganglioma Syndromes
- □ PTEN, DICER1, FH Related Tumor Susceptibility Syndromes
- □ RASopathies and other Rare Genetic Conditions with Increased Cancer Risk
- □ Retinoblastoma and Neuroblastoma Predisposition
- □ Inherited Gastrointestinal Cancer Syndromes
- □ Overgrowth Syndromes and Predisposition to Wilms Tumors and Hepatoblastoma
- □ Multiple Endocrine Neoplasia and Hyperparathyroid-Jaw Tumor Syndromes
- □ **Other,** specify I_____I

Please submit copies of

- Clinic notes summarizing pathologic surveillance results
- CD with radiologic images that demonstrate a (suspected) malignancy

Accompanying Projects

Liquid Biopsy

Informed Consent ☐ Yes ☐ No Date: I__I__II__I__II__I__I

ADDRess

Informed Consent ☐ Yes ☐ No Date: I__I__II__I__II__I__I

Referring physician name and institution I_____I

Address I_____I

Telephone and fax I_____I

email I_____I

Date I__I__II__I__II__I__I Signature _____