

(sending institution: please stamp here):

patient label
name, date of birth, address

phone: (_____) _____ - _____ extension please

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FOLLOW-UP FORM

F

date of examination

day	month	year

Trial: AVD-Rev

Case ID: **CRF ID:**

Current status: CR CR after relapse control necessary ("X" in graphic) active disease ("X" in graphic)

Laboratory:
leucocytes

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 x 10⁶/μl Hb

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 g/dl

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 mmol/l
RBC

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 x 10³/μl thrombocytes

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 x 10³/μl

Secondary malignancies: no Leukemia, MDS NHL Solid Tumor

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 date of diagnosis
(if yes, please specify below and submit reports)

If 'control necessary' or 'active disease', please mark the involved site ("X" = involved or control necessary; "0" = not involved/ CR)

<p>right:</p> <p>1 Waldeyers ring <input type="checkbox"/></p> <p>3 upper cervical/ nuchal/submand. <input type="checkbox"/></p> <p>5 cervical <input type="checkbox"/></p> <p>7a supraclav. <input type="checkbox"/></p> <p>7b infraclav. <input type="checkbox"/></p> <p>9 axillary <input type="checkbox"/></p> <p>11a upper mediastinum <input type="checkbox"/></p> <p>12 lung hilum <input type="checkbox"/></p> <p>17a liver hilum <input type="checkbox"/></p> <p>17b coeliac <input type="checkbox"/></p> <p>18 mesenterial <input type="checkbox"/></p> <p>22 iliacal <input type="checkbox"/></p> <p>24 inguinal/femoral <input type="checkbox"/></p> <p>15 lung right <input type="checkbox"/></p> <p>28 pleura <input type="checkbox"/></p> <p>16 liver <input type="checkbox"/></p> <p>26 bone <input type="checkbox"/></p>		<p>left:</p> <p>2 Waldeyers ring <input type="checkbox"/></p> <p>4 upper cervical/ nuchal/submand. <input type="checkbox"/></p> <p>6 cervical <input type="checkbox"/></p> <p>8a supraclav. <input type="checkbox"/></p> <p>8b infraclav. <input type="checkbox"/></p> <p>10 axillary <input type="checkbox"/></p> <p>11b lower mediastinum <input type="checkbox"/></p> <p>13 lung hilum <input type="checkbox"/></p> <p>19 spleen <input type="checkbox"/></p> <p>20 splenic hilum <input type="checkbox"/></p> <p>21 paraaortal <input type="checkbox"/></p> <p>23 iliacal <input type="checkbox"/></p> <p>25 inguinal/femoral <input type="checkbox"/></p> <p>14 lung left <input type="checkbox"/></p> <p>29 pericardium <input type="checkbox"/></p> <p>27 bone marrow <input type="checkbox"/></p>
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30 other nodal involvement (please specify):

Relapse therapy since last follow-up:
(please submit reports!)

start:

day	month	year

end:

day	month	year

chemotherapy (regimen and cycles):

radiotherapy (irradiation fields and dose):

start:

day	month	year

end:

day	month	year

documentation will be continued in study site
 or in another institution: _____

Remarks:

day	month	year

Investigator signature