COG ACNS1831
Checklist for Submission of Diagnostic Imaging Studies

Patient Initials:_____ Registration #: _____

Sender's Name:_____ Phone #: _____Email**:** _____

Please enclose a copy of this Checklist together with the diagnostic imaging you submit. All materials must be labeled with the protocol and assigned registration number. This study requires electronic data submission for all materials. Valid methods of submission include TRIAD, QARC sFTP, CD, or Dicommunicator. For data sent via sFTP, a notification email should be sent to sFTP@qarc.org *(not an individual's email account)* with the protocol # and registration # in the subject line. Please refer to IROC Rhode Island website for instructions on sending digital data (www.QARC.org). **Please do not submit the same items via multiple submission methods.**

DIAGNOSTIC IMAGING AND REPORTS:

Pre-Study:

_____ Pre-op/biopsy brain MR _____ Post-op/biopsy brain MR

_____ Pre-op/biopsy spine MR _____ Post-op/biopsy spine MR

Brain MR During Therapy (Obtained every 12 weeks):

Date of Scans:

_____ Brain MR _____ Spine MR

End of Therapy:

_____ Brain MR _____ Spine MR

Progression/Relapse:

_____ Brain MR _____ Spine MR

Brain MR Follow-Up Year 1: _____ 3 month _____ 6 month _____ 9 month _____12 month

Brain MR Follow-Up Year 2: _____ 18 month _____ 24 month

Brain MR Follow-up Year 3: _____ 30 month _____ 36 month

Brain MR Follow-up Years: _____ 4 years _____ 5 years _____ 6 years

_____ 7 years _____ 8 years _____ 9 years _____ 10 years

Optional Optical Coherence Tomography (OCT) scans

_____ Pre-treatment (baseline)

_____ 24 weeks (6 months)

_____ 48 weeks (12 months)

_____ End of protocol therapy (if this occurs prior to 48 weeks)

For questions about data submission for imaging studies and reports, please contact us by email (DataSubmission@qarc.org) or phone: **(401) 753-7600** for clarification as necessary. Thank you for your ongoing co-operation

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