

AHOD0831 Request for Diagnostic Review

COG # _____

Patient Initials _____, _____
Last First

Institution Name _____

Please check the appropriate line below:

_____ Patient has completed first cycle of ABVE-PC* Induction chemotherapy.
Review by QARC for PET1 assessment required to report very early response.
(PET1 is done only if previous PET before initiating therapy was positive)

OR

_____ Patient has completed first 2 cycles of Induction chemotherapy. Review
required by QARC prior to patient starting Consolidation Therapy.
Institutional assessment is (*please circle one*): **RER** **SER**

OR

_____ Patient has completed all 4 cycles of ABVE-PC* chemotherapy. Review and
Confirmation required by QARC prior to the start of any Risk-adapted Radiation
Therapy for all patients.

OR

_____ Review of the following imaging study or studies is requested.

Scan type/Date: _____

Purpose of the review: _____

The following items should also be included:

- Radiology reports
- Pertinent clinical information
- Staging and Response Worksheet(s)
- AHOD0831 Data Checklist

Requestor's name _____ Date _____ Best way to contact you after the review:

Phone # _____

Email _____

**Please note the address for QARC: Building A, Suite 201, 640 George Washington Highway, Lincoln, RI
02865-4207**