Eligibility and Registration Worksheet

**Instructions:** The eligibility checklist (A0) must be used to determine and confirm study eligibility status. This information is submitted to ACRIN via the website: www.acrin.org. After entry, the form data will be read only in Rave.

**DEMOGRAPHICS**

**1. Site Registrar (Initials only) __________**

**4. Date Informed Consent Signed ____-____-_______(mm-dd-yyyy) (Must be prior to study entry)**

**5. Patient Initials (last, first, middle) (L, F, M) __________**

**6. Treating Investigator (Site PI) __________**

**10. Ethnicity**
   - Hispanic or Latino
   - Not Hispanic or Latino
   - Not reported
   - Unknown

**11. Gender of a Person:**
   - Male
   - Female
   - Unknown

**12. Country of residence**
   - United States
   - Canada
   - Other

**13. Zip Code (5 digit code, US residents) __________**

**14. Method of Payment**
   - Private Insurance
   - Medicare
   - Medicare and Private Insurance
   - Medicaid
   - Medicaid and Medicare
   - Military or Veteran’s Administration
   - Self Pay (No insurance)
   - No means of payment (No insurance)
   - Military Sponsored (including CHAMPUS & TRICARE)
   - Veterans Sponsored
   - Other
   - Unknown/Decline to answer

**___-____-____ 16. Enrollment Date(= to registration date) (mm-dd-yyyy)**
ACRIN 4703
Detection of Early Lung Cancer
Among Military Personnel (DECAMP)

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___-___-____ 17. Enrollment Date (mm-dd-yyyy)

Race, check all that apply (1=not marked, 2=marked)
19. □ Race: American Indian or Alaskan Native
20. □ Race: Asian
21. □ Race: Black or African American
22. □ Race: Native Hawaiian or Other Pacific Islander
23. □ Race: White
24. □ Race: Not Reported
25. □ Race: Unknown

ELIGIBILITY CHECKLIST

Demography: Age and Birth Year:

26. Year of Birth __________

27. Age (at the time of registration) __________

Inclusion Criteria:
28. Is the patient willing and able to provide written informed consent?
   ○ No
   ○ Yes

29. Is the patient 45 years or older? Note: If enrolling under Amendment 1 or 2, patient must be 50 years or older
   ○ No
   ○ Yes

30. Does the patient have an initial diagnosis of indeterminate pulmonary nodule (0.7-3.0cm)? Note: If enrolling under Amendment 1 or 2, nodule must be 0.7-2.0cm If enrolling under amendment 3 or 4, nodule must be 0.7-2.5cm.
   ○ No
   ○ Yes

31. Indeterminate pulmonary nodule size _______ cm

44. Has the patient had a CT scan within 3 months prior to enrollment?
   ○ No
   ○ Yes

45. Provide the date of CT scan: _____ - _____ - _________ mm-dd-yyyy

32. Is the patient a current or former cigarette smoker with > or = 20 pack years? Note: If enrolling under Amendment 1 or 2, patient must have > or = 30 pack years
   ○ No
   ○ Yes
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33. Provide the pack(s) per day smoked: ______ packs per day

34. Provide the number of year(s) smoked cigarettes ______ years

35. Pack years = number of packs per day X number of years smoked: ______ pack years

36. Is the patient willing to undergo fiberoptic bronchoscopy?
   ○ No
   ○ Yes

37. Is the patient able to tolerate all biospecimen collection as required by protocol?
   ○ No
   ○ Yes

38. Is the patient able to comply with standard of care follow up visits including clinical exams, diagnostic work-ups, and imaging for a minimum of 2 years?
   ○ No
   ○ Yes

39. Is the patient able to fill out the Patient Lung History questionnaire?
   ○ No
   ○ Yes

Exclusion Criteria:

40. Does the patient have a history or previous diagnosis of lung cancer?
   ○ No
   ○ Yes

46. Does the patient have a diagnosis of pure ground glass opacities for the target lesion on chest CT?
   ○ No
   ○ Yes

42. Does the patient have any contraindications to nasal brushing or fiberoptic bronchoscopy including ulcerative nasal disease, hemodynamic instability, severe obstructive airway disease, unstable cardiac or pulmonary disease; inability to protect airway or altered level of consciousness?
   ○ No
   ○ Yes

43. Does the patient have allergies to any local anesthetic that may be used to obtain biosamples in the study?
   ○ No
   ○ Yes

____________________________________  ____________-_________--________ mm-dd-yyyy
Initials of Person(s) Completing This Form  Date Form Completed