Svenska barncancerregistret – VSTB

Base data – formulär

Version 210921

Report date: | 2 | 0 |___|___|___|___|___|___|
Registered by:
Reporting clinical:
Forename:
Surname:
Date of Birth: | 2 | 0 |___|___|___|___|___|___| - |___|___|___|___|
Gender: ☐ **Female** ☐ **Male**
City:
Country:

Diagnostic center

Diagnostic center

- ☐ Stockholm
- ☐ Uppsala
- ☐ Linköping
- ☐ Lund
- ☐ Göteborg
- ☐ Umeå
- ☐ Other

Referring hospital:

_____

Comment:

_____

_____

_____

_____

Diagnostic time intervals

Date first symptom

\| 2 \| 0 \|___\|___\|___\|___\|___\|___\|

☐ **Asymptomatic (screening)**
☐ **En passant finding**

Debut symptoms (maximum 2)

_____

_____

Date first consultation

\| 2 \| 0 \|___\|___\|___\|___\|___\|___\|

Type of consultation

- ☐ Primary care
- ☐ County hospital
- ☐ University hospital

Radiographic imaging procedure carried out

| 2 | 0 |___|___|___|___|___|___|

Date for referral to pediatric oncology center

| 2 | 0 |___|___|___|___|___|___|

Date of first diagnostic procedure

| 2 | 0 |___|___|___|___|___|___|

Date of pathology diagnosis (*If basis of diagnosis are "Biopsy or surgery including histologic examination of tissue" or "Autopsy including histologic examination of tissue" from Notifications of Cancer/tumor data form, please fill in below date***)**

| 2 | 0 |___|___|___|___|___|___|

Comment:

_____
_____
_____
_____

Family history

≥ 2 malignancies at childhood age

☐ Yes ☐ No ☐ Data missing

A parent or a sibling with cancer before 45 years of age

☐ Yes ☐ No ☐ Data missing

If yes, please specify:

_____

Parents are related

☐ Yes ☐ No ☐ Data missing

If yes, please specify:

_____

≥2 first and second degree relatives with cancer before 45 years on same side of family

☐ Yes ☐ No ☐ Data missing

If yes, please specify:

_____

Comment:

_____
_____
_____
_____

Predisposing diseases

Previous cancer?

☐ Yes ☐ No ☐ Data missing

Previous radiotherapy?

☐ Yes ☐ No ☐ Data missing

Predisposing disease/condition

☐ Yes ☐ No ☐ Data missing

Specify predisposing disease/condition (One option**):**

- ☐ ALK Deficiency
- ☐ APC-Associated Adenomatous Polyposis
- ☐ Ataxia Telangiectasia 8 = Beckwith-Wiedemann Syndrome
- ☐ Bloom Syndrome
- ☐ CFC Syndrome
- ☐ Constitutional Mismatch Repair Deficiency
- ☐ Costello Syndrome
- ☐ DICER1 Syndrome
- ☐ Fanconi Anemia
- ☐ Gorlin Syndrome
- ☐ Hereditary Leiomyomatosis and Renal Cell Cancer
- ☐ Hereditary Pheochromocytoma/Paraganglioma Syndrome
- ☐ Juvenile Polyposis Syndrome
- ☐ Legius Syndrome
- ☐ Li-Fraumeni Syndrome
- ☐ Mulibrey (Muscle, Liver, Brain, and Eye) Nanism
- ☐ Multiple Endocrine Neoplasia Type 1
- ☐ Multiple Endocrine Neoplasia Type 2A and 2B
- ☐ Multiple Endocrine Neoplasia Type 4
- ☐ MUTYH-Associated Polyposis 1 = Neurofibromatosis Type 1
- ☐ Ornithin Transcarbamylase Deficiency
- ☐ Perlman Syndrome
- ☐ Peutz-Jeghers Syndrome
- ☐ PHOX2B Deficiency
- ☐ PTEN Harmatoma Tumor Syndrome
- ☐ Retinoblastoma Predisposition
- ☐ Rhabdoid Tumor Predisposition Syndrome
- ☐ Rothmund-Thomson Syndrome
- ☐ Rubinstein-Taybi Syndrome
- ☐ Schinzel-Giedion Syndrome
- ☐ Schwannomatosis
- ☐ Simpson-Golabi-Behmel Syndrome
- ☐ Sotos Syndrome
- ☐ Trisomie 18
- ☐ Tyrosinemia Type 1
- ☐ Von Hippel-Lindau Syndrome
- ☐ WT1-Associated Syndromes
- ☐ Xeroderma Pigmentosum

Congenital abnormalities *(Only fill in If Predisposing disease/condition is yes)*

☐ Yes ☐ No ☐ Data missing

If yes, please specify (*two options*)**:**

- ☐ Organs, bones
- ☐ Oral clefting, teeth, eyes, ears
- ☐ Brain
- ☐ Urogenital
- ☐ Other

If Other, please specify:

_____

Comment:

_____
_____

Constitutional genetic analysis for predisposing disease/condition

☐ Yes ☐ No ☐ Data missing

If yes, please specify (One option):

- ☐ No aberration
- ☐ Genetic aberration of unknown significance
- ☐ Aberration with possible clinical significance
- ☐ Data missing

If Aberration with possible clinical significance, please specify:

_____

Referral to genetic counceling?

☐ Yes ☐ No ☐ Data missing

Comment:

_____
_____
_____

Other factors

Cognitive disability

☐ Yes ☐ No ☐ Data missing

If yes, please specify:

- ☐ Delayed psychomotor development/Mental retardation
- ☐ Autism spectrum disorder
- ☐ ADHD
- ☐ Other

Other anomalies

☐ Yes ☐ No ☐ Data missing

If yes, please specify (One option):

- ☐ Hemihypertrophy
- ☐ Cafe-au-lait spots
- ☐ Vascular skin changes
- ☐ Pancytopenia
- ☐ Anemia
- ☐ Thrombocytopenia
- ☐ Neutropenia
- ☐ Other

Comment:

_____
_____