

Appendix 4 – Minimum Dataset Checklist

Please use this form to determine if patient records collected by your facility correspond to the minimum data requirements stipulated in Standard 3(c) of the CIRSE Standards of Quality Assurance document.

PATIENT DETAILS

- | | | |
|-------------------------------------|---|---|
| <input type="checkbox"/> First Name | <input type="checkbox"/> Date of Birth | <input type="checkbox"/> Responsible |
| <input type="checkbox"/> Last Name | <input type="checkbox"/> Nationality (at birth) | <input type="checkbox"/> Interventional |
| <input type="checkbox"/> Gender | <input type="checkbox"/> Hospital Name | <input type="checkbox"/> Oncologist |

PRESENTATION & HISTORY

- Referral date to the Interventional Oncology service
- Date of Interventional Oncology consultation
- Symptoms recorded, if applicable
- Co-morbidities
- Family history of cancer or predisposing conditions recorded, if applicable
- Nutritional status (*e.g. significant weight loss, major dietary restrictions*)
- Performance status (*ECOG or similar*)

CANCER

- Primary site (ICD10)
- Date of diagnosis
- Histological subtype
- Differentiation (*e.g. well, moderate, poor, undifferentiated, unknown*)
- Laterality (*e.g. left, right, bilateral*)
- Most valid diagnostic method (*e.g. clinical, tumour marker, cytology, histology (metastasis), histology (primary), imaging and other diagnostic techniques, unknown*)
- Stage (*T/N/M/TNM*)
- Maximum diameter of lesion treated

TREATMENT

- | | |
|---|---|
| <input type="checkbox"/> Date of procedure | <input type="checkbox"/> Target site(s) |
| <input type="checkbox"/> Type of procedure | <input type="checkbox"/> Treatment technique |
| <input type="checkbox"/> Name of operator | <input type="checkbox"/> Type of device used (<i>make and model</i>) |
| <input type="checkbox"/> Intention (<i>curative/palliative</i>) | <input type="checkbox"/> Treatment parameters (<i>e.g. device settings, treatment duration</i>) |