

CART-WHEEL Questionnaire Demonstration

Created: December 2009 by CART-WHEEL, Updated Apr 2017



This document contains screenshots of all pages of the questionnaire to give you a better feeling for what we are asking and how the questionnaire works.

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Start page and welcome screen after login



CART-WHEEL

Center for Analysis of Rare Tumors

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Summary

Thank you for being part of CART-WHEEL

A friendly reminder: CONSENT FORM

We are currently in discussions with many researchers interested in using the information that you and other CART-WHEEL participants have provided to further research into rare tumors.

We note that you have not yet given consent for your information to be included in this research. Consent may be given online by clicking [here](#) and following the instructions. You can also click on "My Consent details" at the top of this page.

Alternatively, you can print a copy of the consent form, which you can find [here](#). After you have read and signed the form, it can be scanned (or photographed) and emailed to contact@cart-wheel.org. You can also post the form to:

CART-WHEEL BioGrid Australia
PO Box 2138
Royal Melbourne Hospital VIC 3050 Australia

Start the questionnaire

View your summary

What you might need

It will be useful for you to have a copy of your pathology report with the specific name of your rare tumour, information about the hospitals or medical centres where you have been treated and the names of the treatments that you have received before you start the questionnaire. If you do not have all the required information immediately available you can go back and fill in or modify your responses to those questions at a later date.

FAQ - How to complete the questionnaire

You have questions on how to use the online questionnaire?
Read our [Questionnaire - FAQ \(Frequently Asked Questions\)](#)

Come back to your questionnaire - anytime

You do not have to answer all questions in one session. You can come back and fill in or modify the questionnaire at a later date.

Secure and Confidential

Your information will be entered via a secure connection and cannot be seen by anyone else. At the end of the questionnaire you will be able to print out a summary of all of the questions and your responses to retain for your records.

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Question 1: Personal Details

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1. Your personal details

To allow us to make the best use of the information, we require your personal details to develop a unique identifier number for you. This will allow researchers to analyze your data without identifying you.

All your information is entered via a secure connection and is treated as confidential.

First Name	<input type="text" value="Demo"/>
Middle Initial	<input type="text"/>
Last Name	<input type="text" value="User"/>
Gender	<input type="radio"/> Female <input type="radio"/> Male
Date of Birth	<input type="text"/>
Format: DD/MM/YYYY	

What country were you born in?

What country did you spent most of your life in?

What is your parental cultural background?
Select your main cultural background

Select your second main cultural background if applicable

What is your culture/ethnicity?

Some cancer syndroms are associated with particular racial/religious groups e.g. familial, breast or ovarian cancer and Ashkenazi Jewish Ancestry

Start typing into the text field. You can choose one of the suggestions or enter another name.

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Question 2: Contact Details

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2. Contact Details

Please enter your contact details. All entered information is treated confidential and will not be given out.

First Name	<input type="text"/>
Last Name	<input type="text"/>
Address	<input type="text"/>
Zip/Postcode	<input type="text"/>
Town/Suburb	<input type="text"/>
State	<input type="text"/>
Country	<input type="text" value="Please select"/>
Email	<input type="text"/>
Phone	<input type="text"/>

2a. Second Contact Details

Please enter details for a second contact person if possible.

First Name	<input type="text"/>
Last Name	<input type="text"/>
Email	<input type="text"/>
Confirm Email	<input type="text"/>

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Question 3: Diagnosis (Tumor/Cancer)

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3.1 Have you been diagnosed with a Tumor (cancer)?

☒ Yes

☐ No

If you have a [Biopsy/Histology report](#) from your doctor please type in the diagnosis as shown on the report.

If you have had any other tumors (cancer) apart from this tumor (cancer) you can specify this in Question 15.

Start typing [the name of the tumor \(cancer\)](#) into the text field. You can choose one of the suggested types which will appear or enter another name.

3a. When was your tumor (cancer) first diagnosed?

Please select the date corresponding to the date on which your tumor was diagnosed. If you are not sure, please select a date around the time that you recall your tumor was first diagnosed and click on the box saying 'Estimated Date'.

Format: DD/MM/YYYY

☐ [Estimated Date](#)

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Question 3: Diagnosis (No Tumor/Cancer i.e. Predisposition)

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3.1 Have you been diagnosed with a Tumor (cancer)?

- ☐ Yes
☒ No

3.2 Have you been diagnosed with an inherited syndrome associated with the development of cancer (for example familial Adenomatous Polyposis, HNPCC, Li-Fraumeni, Multiple Endocrine Neoplasia)??

- ☒ Yes
☐ No
☐ I don't know

3.3 Have you tested positive for a family cancer gene?

- ☒ Yes
☐ No
☐ I don't know

Which gene/s have you been tested for?

Start typing the name of the gene into the text field. You can choose one of the suggested genes that appear or enter another name. If you don't know the name, enter "unknown". To enter another gene, please click 'Add another gene'.

Gene name: Was a gene abnormality found?

[Show Genes list](#)

[Add another gene](#)

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Question 4: Tumor Location

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4. Where was your tumor (cancer) thought to have started from in your body?

The location is not in the list? Please select 'Other' and specify.

First, select the region of your body:

Please select ▼

Next, select the location of the tumor:

Please select ▼

4a. Where else was the tumor (cancer) located in your body?

You can select one or more locations from the list below. Just select as many as you are aware of.

Expand the options by clicking on ☐.

Collapse the options by clicking on ☐.

The location is not in the list? Please select 'Other' and specify.

- ☐ Abdomen
- ☐ Bone
- ☐ Bone marrow
- ☐ Breast
- ☐ Chest
- ☐ Head and Neck
- ☐ Lymph nodes
- ☐ Muscle
- ☐ Pelvis
- ☐ Skin
- ☐ Other

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Question 4: Tumour Location (No tumor)



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Question 4: Tumour Location

As you do not have a tumor, this question does not apply to you.

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Question 5: Hospitals

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Click here for a summary of the whole page, or place the cursor over any of the underlined words for a description

5. Which hospitals have been involved in your care?

Please list the main hospitals where you have been treated for this tumor. For example, where you had an operation, medical treatment such as chemotherapy or any other therapy. Once you have entered the first hospital/institution you can enter additional.

Click 'Save to add hospital' (or 'SAVE' at the bottom at the page) to add the hospital to your hospital list. You can edit the hospital information later. If you don't know the address, leave the field empty.

Add Hospital details

Country

Please select ▼

Hospital Name

Start typing the name and choose from the suggestions or enter another

If you chose one of the suggestions, press "Enter" or click outside the field for the address to appear automatically

Address

Zip/Postcode

Town/Suburb

State

Clear

Save to add hospital

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Question 6: Doctors

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Click here for a summary of the whole page, or place the cursor over any of the underlined words for a description

6. Which doctors have been involved in your care?

Please list the main doctors you have been visiting during your care (i.e. GP, Surgeon, Oncologist ...).

Click 'SAVE' to add the doctor to your doctor list. You can edit the doctor's information later. If you don't know the address, leave the field empty. If you have seen the doctor at a hospital, you can choose from the list of hospitals that you have already entered or choose 'Other' from the list to enter a new hospital.

Add Doctor details

Specialty

Please select ▼

Doctor's Name

Address

Seen at hospital directly:

Please select ▼

If seen elsewhere, please enter:

Address

Zip/Postcode

Town/Suburb

State

Country

Please select ▼

Clear

Save to add Doctor

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Question 7: Biopsy Details

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7. Where and when was the biopsy of your tumor (cancer) taken?

Please provide details from where the biopsy in your body was taken, when and at which center the biopsy was performed. The Hospitals/Doctors you have already entered will appear in the drop down boxes for you to select. If the Hospital/Doctor is not in the list, please choose 'Other' and specify.

Click 'SAVE'. Once you have entered the first, you can enter details of additional biopsies(/operations) if appropriate.

From where in your body was the biopsy taken?

If not one of your selected sites, then choose 'Other' from the list and select details.

Please select ▼

Date Biopsy taken:

Format: DD/MM/YYYY

☐ [Estimated Date](#)

At what center was the biopsy performed?

[Doctor:](#)

Please select ▼

and/or

[Hospital:](#)

Please select ▼

and/or

other Center:

Was [tissue banking](#) performed?

☐ Yes

☐ No

☐ I don't know

Clear

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Question 7: Biopsy Details (No Tumor)



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Question 7: Biopsy details

As you do not have a tumor, this question does not apply to you.

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Question 8: Operation Details

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Click here for a summary of the whole page, or place the cursor over any of the underlined words for a description

8. Have you had an operation for your tumor (cancer)?

Have you had surgery on your tumor (cancer)?

☒ Yes

☐ No

These details may be the same as for the biopsy.

Please enter details about the operation and click 'SAVE'. Once you have entered the first, you can enter additional.

Type of operation:

Please select ▼

Where in your body was the surgery performed?

Please select ▼

Operation Date:

Format: DD/MM/YYYY

☐ Estimated Date

Where did you have the surgery?

Doctor:

Please select ▼

and/or Hospital:

Please select ▼

Clear

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Question 8: Operation Details (No Tumor)

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8. Have you had prophylactic surgery for precancerous tissue?

Have you had surgery to reduce the change of you developing cancer such as removal of breast(s) or removal of testicles? (This does not include biopsies or removal of nodes)

- ☒ Yes
☐ No

These details may be the same as for the biopsy.

Please enter details about the operation and click 'SAVE'. Once you have entered the first, you can enter additional.

Type of operation:

Please select ▼

Operation Date:

Format: DD/MM/YYYY

☐ Estimated Date

Where did you have the surgery?

Doctor:

Please select ▼

and/or Hospital:

Please select ▼

Clear

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Question 8: Operation Details (Patient with Predisposition Develops Tumor)

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8. Have you had an operation for your tumor (cancer)?

Have you had surgery on your tumor (cancer)?

- ☒ Yes
☐ No

8. Have you had prophylactic surgery for precancerous tissue?

Have you had surgery to reduce the change of you developing cancer such as removal of breast(s) or removal of testicles? (This does not include biopsies or removal of nodes)

- ☒ Yes
☐ No

TUMOUR or PROPHYLACTIC surgery?

TUMOUR: an operation for your tumor

PROPHYLACTIC: A surgery to reduce the change of you developing cancer

TUMOR

These details may be the same as for the biopsy.

Please enter details about the operation and click 'SAVE'. Once you have entered the first, you can enter additional.

Type of operation:

Please select

Where in your body was the surgery performed?

Please select

Operation Date:

Format: DD/MM/YYYY

☐ Estimated Date

Where did you have the surgery?

Doctor:

Please select

and/or Hospital:

Please select

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Question 9: Treatment Details

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9. Have you had any drug treatment for your tumor (cancer) prescribed by a doctor?

This includes Chemotherapy, Hormone therapy, Targeted therapy, Anti-angiogenic therapy, Vaccine therapy and Immuno therapy. It does NOT include radiation therapy, the question on the next screen will ask you about possible radiation treatments.

- ☒ Yes
☐ No

Please describe the course of treatment you received and click "SAVE". Once you have entered the first, you can enter additional.

Where did you have the treatment?

Doctor:

Please select ▼

and/or Hospital:

Please select ▼

Name of treatment:

Start typing the name of the treatment and choose from the suggestions or enter other.

How did you access this treatment?

Please select ▼

When did this course of treatment start?

Format: DD/MM/YYYY

☐ [Estimated Date](#)

When did this course of treatment end?

Format: DD/MM/YYYY

☐ The treatment is still ongoing

☐ The treatment ended

☐ [Estimated Date](#)

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Question 9: Treatment Details (No Tumor)

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9. Have you received medication to reduce the chance of you developing a cancer? E.g. tamoxifen to prevent breast cancer or aspirin to prevent bowel cancer?

- ☒ Yes
☐ No

Please describe the course of treatment you received and click "SAVE". Once you have entered the first, you can enter additional.

Where did you have the treatment?

Doctor:

Please select ▼

and/or Hospital:

Please select ▼

Name of treatment:

Start typing the name of the treatment and choose from the suggestions or enter other.

How did you access this treatment?

Please select ▼

When did this course of treatment start?

Format: DD/MM/YYYY

☐ Estimated Date

When did this course of treatment end?

Format: DD/MM/YYYY

☐ The treatment is still ongoing

☐ The treatment ended

☐ Estimated Date

Clear

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Question 9: (Patient with predisposition develops a Tumor/Cancer)

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9. Have you had any drug treatment for your tumor (cancer) prescribed by a doctor?

This includes Chemotherapy, Hormone therapy, Targeted therapy, Anti-angiogenic therapy, Vaccine therapy and Immuno therapy. It does NOT include radiation therapy, the question on the next screen will ask you about possible radiation treatments.

- ☒ Yes
☐ No

9. Have you received medication to reduce the chance of you developing a cancer? E.g. tamoxifen to prevent breast cancer or aspirin to prevent bowel cancer?

- ☒ Yes
☐ No

Please describe the course of treatment you received and click "SAVE". Once you have entered the first, you can enter additional.

Why did you have this treatment?

Where did you have the treatment?
Doctor:

and/or Hospital:

Name of treatment:

How did you access this treatment?

When did this course of treatment start?
Format: DD/MM/YYYY ☐ [Estimated Date](#)

When did this course of treatment end?
Format: DD/MM/YYYY ☐ The treatment is still ongoing
☐ The treatment ended ☐ [Estimated Date](#)

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Question 10: Treatments Side Effects

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10. Have you had any side effects during your treatment ?

☒ Yes

☐ No

Please enter the treatment and describe the side effects you have experienced with it. Click "SAVE". Once you have entered the first, you can enter additional treatments.

Please select the type(s) of side effect that you experienced

- | | | | |
|---------------------------------------------|----------------------------------------------|-------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Eye irritation | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Nausea and Vomiting |
| <input type="checkbox"/> Allergic reaction | <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Nerve problems |
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Hand-foot syndrome | <input type="checkbox"/> Liver problems | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Bladder irritation | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Low platelets (thrombocytopenia) | <input type="checkbox"/> Peptic ulcer |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Low white cell count (neutropenia) | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Minor bruising | <input type="checkbox"/> Rituximab infusion reaction |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Tiredness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Infection | <input type="checkbox"/> Muscle pain | |
| <input type="checkbox"/> Other | | | |

Please enter the name of the drug if known:

If you do not know which drug caused the side effect please enter unknown

Clear

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Question 11: Radiation Details

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11. Have you ever had radiation treatment for this tumor (cancer)?

☒ Yes

☐ No

Please describe the radiation treatment you received and click "SAVE". Once you have entered the first, you can enter additional.

Where did you have the radiation treatment?

Doctor:

Please select ▼

and/or Hospital:

Please select ▼

When did this course of radiation start?

Format: DD/MM/YYYY

☐ Estimated Date

When did this course of radiation end?

Format: DD/MM/YYYY

☐ Estimated Date

What part of your body received the radiation treatment?

Please select ▼

Have you been asked to stop this radiotherapy because of side effects?

☐ Yes

☐ No

Have you experienced any late side effects?

☐ Yes

☐ No

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Question 11: Radiation Details (No Tumor)



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Question 11: Radiation deatails

As you do not have a tumor, this question does not apply to you.

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Question 12: Clinical Trial Details

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12. Have you ever been in a clinical trial for your tumor (cancer) or your genetic risk for cancer?

☒ Yes

☐ No

Please describe the clinical trial and click "SAVE". Once you have entered the first, you can enter additional.

Hospital:

Please select ▼

Name or type of trial:

Name of treatment (if relevant):

Year when clinical trial started:

e.g. 2006

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Question 13: General Health

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13. Your general health

If you are not sure of the answer to a question please select 'No'

Have you ever had a heart attack?

Please select ▼

Have you ever been treated for heart failure?

Please select ▼

Have you had an operation to unclog or bypass the arteries in your legs?

Please select ▼

Have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or transient ischemic attack (TIA)?

Please select ▼

Do you have difficulty moving an arm or leg as a result of a stroke or cerebrovascular accident?

Please select ▼

Do you take medication for asthma?

Please select ▼

Do you take medication for emphysema, chronic bronchitis, or chronic obstructive lung disease?

Please select ▼

Do you have stomach ulcers, or peptic ulcer disease?

Please select ▼

Do you have diabetes (high blood sugar)?

Please select ▼

Have you ever had the following problems with your kidneys?

Please select ▼

Do you have one of the following conditions?
(Please check all that apply)

- ☐ Rheumatoid arthritis
- ☐ Lupus (Systemic Lupus Erythematosus)
- ☐ Polymyalgia Rheumatica
- ☐ Alzheimer's Disease or Dementia
- ☐ Cirrhosis or serious liver damage
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Another Cancer
- ☐ HIV

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Question 14: Smoking/Alcohol Consumption

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14. Do you currently smoke ?

- ☒ Yes
- ☐ No but I smoked in the past
- ☐ No, I have never smoked

At what age did you start smoking?

How many cigarettes do you smoke per day?

14a. Do you drink alcohol?

- ☒ Yes
- ☐ No but I consumed alcohol in the past
- ☐ No, I have never drunk alcohol

Number of days on which alcohol is consumed in an average week:

Average number of standard drinks consumed per day :
(100mL wine, 375mL beer, 30mL spirit)

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Question 15: Other Tumors

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15. Have you had any other tumor (cancer) apart from this tumor (cancer)?

☒ Yes

☐ No

Please enter details about the tumor and click 'SAVE'. Once you have entered the first, you can enter additional.

Type of tumor:

Start typing the type of cancer and choose from the suggestions or enter another name.

Date diagnosed:

Format: DD/MM/YYYY

☐ Estimated Date

Where was this tumor diagnosed?

Doctor:

Please select ▼

and/or

Hospital:

Please select ▼

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Question 15: Other Tumors (No Tumor)



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Question 15: Other Tumours

As you do not have a tumor, this question does not apply to you.

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Question 16: Family Cancer History

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16. Do you have a family history of cancer?

☒ Yes

☐ No

Please enter the type of tumor with the number of family members below and click 'SAVE'. Once you have entered the first, you can enter additional.

Type of tumor:

Start typing the type of cancer and choose from the suggestions or enter another name.

Relationship to you:

Brothers, Sisters
and Children:

Number of family members with this type of cancer:

Youngest age of family member when diagnosis made

Mother's side:

Number of family members with this type of cancer:

Mother, grandparents, aunts, uncles, cousins, if known

Youngest age of family member when diagnosis made

Father's side:

Number of family members with this type of cancer:

Father, grandparents, aunts, uncles, cousins, if known

Youngest age of family member when diagnosis made

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Question 17: Family Gene Test

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17. Have you or anyone in your family been tested for an inherited cancer ?

This includes testing of either blood or tumor from a family member.

- ☒ Yes
☐ No
☐ I don't know

Please enter details about the test and click 'SAVE'. Once you have entered the first, you can enter additional.

Where have you or your family been tested?

Doctor:

and/or Hospital:

Have you been diagnosed with an inherited syndrome associated with the development of cancer (for example Familial Adenomatous Polyposis, HNPCC, Li-Fraumeni, Multiple Endocrine Neoplasia)?

- ☒ Yes
☐ No
☐ I don't know

Name of Syndrome Start typing the name of the syndrome into the text field and choose from the suggestions or enter another name.

[Show Syndromes list](#)

Have you or a family member been tested for a gene associated with an inherited cancer (for example BRCA1, MLH1, APC, p53)?

- ☒ Yes
☐ No
☐ I don't know

Which gene/s have you been tested for? Start typing the name of the gene into the text field. You can choose one of the suggested genes that appear or enter another name. If you don't know the name, enter "unknown". To enter another gene, please click 'Add another gene'.

Gene name: Was a gene abnormality found? [Show Genes list](#)

[Add another gene](#)

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Question 18: Tumour Gene Test

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18. Has your tumor (cancer) been tested for a cancer related gene ?

This may be unrelated to a family member being tested.

- ☒ Yes
☐ No
☐ I don't know

Please enter details about the test and click 'SAVE'. Once you have entered the first, you can enter additional.

Where have you been tested?

Doctor:

and/or Hospital:

If your tumor has been tested for a cancer related marker do you know the result of the testing?

☐ No, I don't know

If Yes, do you know the result of the test?

Was abnormality found in any of the following genes?

Genes	Gene abnormality
<input type="checkbox"/> b raf	
<input type="checkbox"/> c KIT	
<input type="checkbox"/> c MET	
<input type="checkbox"/> EGFR	
<input type="checkbox"/> k ras	
<input type="checkbox"/> n ras	
<input type="checkbox"/> PDGFRA	
<input type="checkbox"/> PI3K	
<input type="checkbox"/> EML4 ALK	
<input type="checkbox"/> STK11	
<input type="checkbox"/> SMAD4	
<input type="checkbox"/> BMPR1A	
<input type="checkbox"/> MSH2	
<input type="checkbox"/> MLH1	
<input type="checkbox"/> MSH6	
<input type="checkbox"/> MYD88	
<input type="checkbox"/> CXCR4/WHIM	

Was your tumor positive for any of the following proteins?

Protein	Positivity
<input type="checkbox"/> Her 2	
<input type="checkbox"/> ER	
<input type="checkbox"/> PR	

If there were other genes tested which are not in the lists please add them below (e.g. "FGFR3, TAP15, STL"). If you don't know the name, enter "unknown".

Gene name: Was a gene abnormality found?

[Add another gene](#)

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Question 18: Tumour Gene Test (Tumor)



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Question 18: Tumour gene test

As you do not have a tumor, this question does not apply to you.

Question 19: Additional Data Collection Projects (No project)



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Question 19: Additional Data Collection Projects

There is no project associated with your tumour, therefore this question does not apply to you.

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Question 20: Psychosocial

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20. Below is a list of difficulties people sometimes have after a diagnosis of cancer. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS. How much have you been distressed or bothered by these difficulties?

If you would like your responses to be suitable for a research project, please answer all 6 questions.

Please note: The questions are answerable only once a day and cannot be edited once saved.

I thought about my cancer when I didn't mean to:

Please select ▼

I felt watchful or on-guard:

Please select ▼

Other things kept making me think about my cancer:

Please select ▼

I was aware that I still had a lot of feelings about my cancer, but I didn't deal with them:

Please select ▼

I tried not to think about my cancer:

Please select ▼

I had trouble concentrating:

Please select ▼

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Question 21: Comments

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21. Is there anything you would like to add?

Please enter your comments here:

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CART-WHEEL

Center for Analysis of Rare Tumors

QUESTIONNAIRE

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Summary

Thank you for taking part in CART-WHEEL.

Print

Save

Your information has been submitted to the CART-WHEEL database.
You can return to your questionnaire and modify your responses later at anytime by using your login details.

A friendly reminder: CONSENT FORM

We are currently in discussions with many researchers interested in using the information that you and other CART-WHEEL participants have provided to further research into rare tumors.

We note that you have not yet given consent for your information to be included in this research. Consent may be given online by clicking [here](#) and following the instructions. You can also click on "My Consent details" at the top of this page.

Alternatively, you can print a copy of the consent form, which you can find [here](#). After you have read and signed the form, it can be scanned (or photographed) and emailed to contact@cart-wheel.org. You can also post the form to:

CART-WHEEL, Biocent Australia
PO Box 2238
Royal Melbourne Hospital VIC 3000 Australia

Summary of your information

Please read the summary thoroughly. If you wish to change some of the details or add information, please click on the button "Edit" near the appropriate field.

1. Personal Details

Edit

2. Contact Details

Edit

2a. Second Contact Details

Edit

Name:

Demis User

Date of Birth:

Sex:

Born in:

Mostly lived:

Background:

Culture:

Other

Name:

Address:

Postcode:

Suburb:

State:

Country:

Email:

Phone:

3./4. Diagnosis

Edit

Tumour type:

Previous symptomatic involvement (before surgery):

Previous placental cell disease (menstrual):

Tumour marker involvement (DNA):

Biopsy marker result is from:

Date of Diagnosis:

Tumour site (primary):

Tumour sites (secondary):

5. Hospitals

Edit

You have no hospitals specified

6. Doctors

Edit

You have no doctors specified

7. Biopsy details

Edit

You have no biopsy specified

8. Operation details

Edit

You have no operation specified

9. Treatment details

Edit

You have no treatment specified

10. Treatment side effects

Edit

You have no treatment side effect specified

11. Radiotherapy details

Edit

You have no radiotherapy specified

12. Clinical trial details

Edit

You have no clinical trial specified

13. General Health

Edit

Have you ever had a heart attack?

Have you ever been treated for heart failure?

Have you had an operation to unclog or bypass the arteries in your legs?

Have you had a stroke, cerebrovascular accident, blood clot or bleeding in the brain, or transient ischaemic attack (TIA)?

Do you have difficulty moving an arm or leg as a result of a stroke or cerebrovascular accident?

Do you take medication for asthma?

Do you take medication for emphysema, chronic bronchitis, or chronic obstructive lung disease?

Do you have stomach ulcers, or peptic ulcer disease?

Do you have diabetes (high blood sugar)?

The diabetes has caused the following problems:

Have you ever had the following problems with your kidneys?

You have selected the following conditions:

You have no medical conditions specified

14. Smoking

Edit

Smoking:

Current

Age:

Cigarettes/Day:

14a. Alcohol consumption

Edit

Alcohol:

Current

Number of days in a week:

Number of drinks per day:

15. Other tumors

Edit

You have no other tumor specified

16. Family cancer history

Edit

You have no cancer history in your family specified

17. Family gene tests

Edit

You have no family gene test specified

18. Tumor gene tests

Edit

You have no tumor gene test specified

19. Additional Data Collection Projects

Edit

There is no project associated with your tumour, therefore this question does not apply to you.

THERE ARE NO PATHOLOGY RESULTS ENTERED TO GENERATE A GRAPH

20. Psychosocial

Edit

You haven't answered psychosocial questions

21. Comments

Edit

You entered no comments

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CART-WHEEL Home

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Contact Us

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Settings: My Login Details

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CART-WHEEL
Center for Analysis of Rare Tumors

QUESTIONNAIRE

Your CART-WHEEL Login details

This page allows you to modify your current CART-WHEEL account settings. (* is required)



First Name *	<input type="text" value="Demo"/>
Last Name *	<input type="text" value="User"/>
Username	<input type="text" value="demouser"/>
Login Email address *	<input type="text"/>
<u>Password</u> *	<input type="password"/>
Re-type Password *	<input type="password"/>

Save my settings



1. Security Question:

Choose Question 1 ...	▼
Answer:	<input type="text"/>

2. Security Question:

Choose Question 2 ...	▼
Answer:	<input type="text"/>

Save Questions

Contact Us

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Cart-Wheel (BioGrid Australia)
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Royal Melbourne Hospital
Victoria, 3050, Australia

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Frequently Asked Questions

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