**Appendix C Reporting proforma for bone tumour reports**

Surname\*…………………………….… Forenames\*……………..……… Date of birth\*……………… Sex\*…......

Hospital\*………….……….……….…… Hospital no\*………..……..……. NHS/CHI no……………………..….…

Referring organisation\* ………………………………………… Reporting organisation\* ……………….…………

Authorising pathologist\*……….…………………………..…… Surgeon\*…………………………………….….….

Date of receipt\*……………………………………………….…. Date of reporting\*………..….…………………….

Report no………………………....…… Report type ..………………………………………………………………..

**CLINICAL INFORMATION**

**Specimen type\*:** Closed (needle) biopsy □ Open (surgical) biopsy □ Curettage □ Excision □

**­­Specimen size (in three dimensions in mm):** ………………………

**Anatomical bone sampled\***: ……………………………………………

**Tumour location in bone\***: Epiphysis/apophysis □ Metaphysis □ Diaphysis □ Cortex □ Medulla □

Periosteal □ Extraosseous (soft tissue) □ Joint-based tumour involving bone □ Not definable □

**Laterality\***: Left □ Right □ Midline □ Not known □ Not applicable □

**PATHOLOGICAL INFORMATION**

**Tumour size (in three dimensions in mm):\*** ………………………………….……

**Histological diagnosis of tumour type\*:** ……………………………………………

**Tumour grade\*:** Low grade (G1) □ Low grade (G2) □ High grade (G3) □

**Extent of local tumour spread (for medullary tumours only)\*:** Intracompartmental □ Extracompartmental □

If extracompartmental: Joints □ Extraosseus soft tissues □

**Distance to proximal bone margin:**  **…………….mm**

**Distance to distal bone margin: …………….mm**

**Distance to other relevant bone resection margin:** **…………….mm (please specify………………….….)**

**Distance to closest soft tissue resection margin: …………….mm**

**Type of tissue at closest soft tissue margin\*:** Muscle □ Fat □ Loose fibrous tissue □

Dense fibrous tissue □ Tumour □

**Is the histological diagnosis confirmed by cytogenetic or molecular tests?\***

Yes, confirmed □ No, not confirmed □ Test not done □

**Cytogenetic and molecular genetic findings (where applicable):** …………………………………….

**Tumour necrosis in response to preoperative therapy:** ………%\* Not applicable □

UICC TNM (8th edition)\*: (y)pT …….. (y)pN …….. (y)pM ……..

**SNOMED codes\*:** T…………… M…………..

**COMMENTS\* = required for COSD**

**Pathologist ………………………….. Date………………………………**