ARISTOTLE
DEATH FORM

Trial Number A R I – ☐☐☐ **Patient Initials** ☐☐☐

1. DEATH

A) Date patient last seen: d d / m m / y y y y

B) Date of death: d d / m m / y y y y

C) Cause of death *(tick all that apply)*:

☐ Rectal cancer ☐ Chemotherapy related ☐ Radiotherapy related

☐ Surgery related ☐ Other, please specify _____

2. POST MORTEM

A) Post mortem performed? ☐ Yes ☐ No

PLEASE SEND POST MORTEM REPORT TO THE TRIALS CENTRE

3. SITE(S) OF CANCER PRESENT AT TIME OF DEATH

LOCOREGIONAL (below sacral promontory)

A) Local?	☐ Yes	☐ Suspected	☐ No	
B) Node?	☐ Yes	☐ Suspected	☐ No	Site(s): _____
C) Peritoneum?	☐ Yes	☐ Suspected	☐ No	
D) Other locoregional *(specify)*:	☐ Yes	☐ Suspected	☐ No	Site(s): _____

DISTANT (above sacral promontory)

E) Node?	☐ Yes	☐ Suspected	☐ No	Site(s): _____
F) Peritoneum?	☐ Yes	☐ Suspected	☐ No	
G) Liver?	☐ Yes	☐ Suspected	☐ No	
H) Lung?	☐ Yes	☐ Suspected	☐ No	
I) Brain?	☐ Yes	☐ Suspected	☐ No	
J) Other distant *(specify)*:	☐ Yes	☐ Suspected	☐ No	Site(s): _____

4. SECOND (UNRELATED) MALIGNANCY

A) Second unrelated malignancy? ☐ Yes ☐ No

i) If yes, site: _____

ii) Is there histological evidence? ☐ Yes ☐ No

PLEASE SEND PATHOLOGY REPORT TO THE TRIALS CENTRE

Completed by:	**Signature:**	**Date completed** *(dd/mm/yyyy)*:

TRIALS OFFICE USE ONLY

Form received:	Form entered:	Form checked