ARISTOTLE

Trial Number: A R I — ☐☐☐ **Patient Initials:** ☐☐☐

FOLLOW UP FORM: 12 MONTHS

***NB** All dates should be in DD-MM-YYYY format*

INSTRUCTIONS:
If confirmed residual disease or recurrence has been reported prior to this visit, please complete sections1 and 3 **only**.

1. DATE OF LAST CONTACT

A) Date patient last known to be alive: ☐☐ / ☐☐ / ☐☐☐☐

i) How was this information obtained? *(tick one box only)*

☐ Patient attended for clinic visit ☐ Telephone call with patient ☐ Via GP ☐ Via local hospital

☐ Via hospice ☐ Other *(please specify)* _____

If the patient has died since the last visit please submit a death form

2. PHYSICAL EXAMINATION

A) ECOG Performance Status: ☐ **OR** ☐ N/A (patient did not attend)

3. DISEASE STATUS

A) Has the patient's disease recurred since the last visit *(tick one box only)*?

☐ Yes—suspected *(complete a Suspected Residual Disease or Recurrence form)* ☐ Unknown

☐ Yes—confirmed *(complete a Confirmed Residual Disease or Recurrence form)* ☐ N/A—patient had residual disease after CRT

☐ No ☐ N/A—confirmed recurrence reported previously

4. ADJUVANT CHEMOTHERAPY

A) Did this patient receive adjuvant chemotherapy? ☐ Yes ☐ No ☐ Unknown

i) If yes, give date of completion of adjuvant chemotherapy: ☐☐ / ☐☐ / ☐☐☐☐

ii) If yes, give duration of adjuvant chemotherapy: ☐☐ months

5. SURGERY FOR LATE EFFECTS OF RADIOTHERAPY

A) Has the patient required surgery for late effects of radiotherapy since the last visit? ☐ Yes ☐ No ☐ Unknown

i) If yes, date of surgery: d d / m m / y y y y

ii) If yes, was this for:

☐ Bleeding

☐ Blockage (stricture)

☐ Other *(please specify)* _____

6. SECOND (UNRELATED) MALIGNANCY

A) Has the patient developed a second unrelated malignancy since the last visit? ☐ Yes ☐ No

i) If yes, specify type: _____

ii) Is there histological evidence? ☐ Yes ☐ No

Please send a copy of the pathology report to the Trials Centre if available.

For UCL CTC use only: Date Checked: _____ Initials: _____ Date entered: _____ Initials: _____

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7. CT SCAN

Date of scan: ☐☐ / ☐☐ / ☐☐☐☐ ☐ No metastatic lesions detected*

** This should only be selected if no metastatic lesions were listed at baseline - see instructions below.*

Lesion No	Site (please provide a detailed description, e.g. Left lower lobe lung)	Lesion assessment E = equivocal U = unequivocal NV = not visible
1		
2		
3		
4		
5		
6		
7		
8		

Instructions:

1. Please list sites of metastatic disease only, not the primary tumour *(NB If patient has residual disease, please complete a Confirmed Residual Disease or Recurrence Form)*. If no metastatic lesions have been detected, tick the box above.
2. Any lesions reported at baseline should be reported here, using the same lesion number. If the lesion is no longer visible, enter NV
3. Once a lesion has been added to the table, it should be reported on subsequent forms, using the same lesion number. If it is not visible on subsequent scans, enter NV.
4. If there is more than one lesion in the same site, please record only up to a maximum of two lesions per site in the table.

8. PELVIC FUNCTIONAL QUESTIONNAIRE

A) Has the patient completed a pelvic functional questionnaire? ☐ Yes ☐ No

i) If **Yes,** date questionnaire completed: ☐☐ / ☐☐ / ☐☐☐☐

ii) If **No**, please give reason: ☐ Patient too ill ☐ Patient refused ☐ Patient did not consent ☐ Administrative error

☐ Other *(specify):* _____

9. DEFUNCTIONING STOMA

A) Does the patient have a defunctioning stoma? ☐ Yes ☐ No

i) If yes, what type: ☐ Ileostomy ☐ Colostomy

ii) If yes, is it intended to be temporary or permanent? ☐ Temporary ☐ Permanent

Completed by (print name):	Signature:	Date Completed:

Site:

For UCL CTC use only: Date Checked: _____ Initials: _____ Date entered: _____ Initials: _____