ARISTOTLE

FOLLOW UP FORM (3, 6, 12 months)

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

Visit Date: d d / m m / y y y y **Follow-up Month:** ☐ 3 ☐ 6 ☐ 12

1. GENERAL

A) Is the patient alive? ☐ Yes ☐ No

B) Did the patient attend the visit? ☐ Yes ☐ No

IF PATIENT HAS DIED, PLEASE COMPLETE A DEATH FORM

2. PHYSICAL EXAMINATION

A) Weight : ☐☐☐ • ☐ kg

B) ECOG performance status: ☐

C) Perineal wound healing (if present): ☐ Healed ☐ Not yet healed ☐ N/A

3. CT SCANS (At 12 months post CRT only)

A) Date of chest CT: d d / m m / y y y y

i) Recurrence: ☐ Not present ☐ Suspected ☐ Confirmed

B) Date of abdomen CT: d d / m m / y y y y

i) Recurrence: ☐ Not present ☐ Suspected ☐ Confirmed

C) Date of pelvis CT: d d / m m / y y y y

i) Recurrence: ☐ Not present ☐ Suspected ☐ Confirmed

IF THERE IS A SUSPECTED/CONFIRMED RECURRENCE, PLEASE COMPLETE RECURRENCE FORM

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

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Form received:	Form entered:	Form checked

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4. POST-OPERATIVE CHEMOTHERAPY

a) Is patient planned to receive chemotherapy? ☐ Yes ☐ No

b) If yes, give details of planned post-operative chemotherapy

☐ 5FU/leucovorin ☐ Capecitabine

☐ Oxaliplatin + Capecitabine ☐ Oxaliplatin + 5FU/leucovorin

☐ Other *(please specify)* _____

c) Please provide start date of chemotherapy: d d / m m / y y y y

i) Is this date actual or planned? ☐ Actual ☐ Planned

d) Date chemotherapy was finished: d d / m m / y y y y ☐ Still continuing

5. SURGERY

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

If yes, was this for:

☐ Bleeding ☐ Blockage (stricture) ☐ Other (please specify:

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

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