ARISTOTLE

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

FOLLOW UP FORM

☐ 24 months ☐ 36 months

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

FU24-36-1/2

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

☐ N/A (patient did not attend)

A) Weight (kg): ☐☐☐.☐

B) ECOG Performance Status: ☐

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)*

☐ Yes—confirmed *(complete a Confirmed Residual Disease or Recurrence form)*

☐ No

☐ Unknown

☐ N/A—patient had residual disease after CRT

☐ N/A—confirmed recurrence reported previously

4. 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: ☐☐ / ☐☐ / ☐☐☐☐

ii) If yes, was this for:

☐ Bleeding

☐ Blockage (stricture)

☐ Other *(please specify)* _____

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

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FU24-36-2/2

5. CT SCAN

Date of scan: ☐☐ / ☐☐ / ☐☐☐☐ ☐ No metastatic lesions detected *(see point1 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 *(NB If patient has evidence of re-currence, please complete a Suspected or Confirmed Residual Disease or Re-currence Form)*. If none detected, tick the box above.
2. Once a lesion has been added to the table, it should not be removed from subsequent forms. If it is not visible on subsequent scans, enter NV.
3. Please assign the same lesion the same lesion number throughout.
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.

6. 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):* _____

7. 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: _____