NEAT TRIAL — ANNUAL FOLLOW-UP FORM

Trial No.

Patient Name: .....
Date of Birth: ____/____/____
Hospital: .....
Hospital No.: .....
Consultant: .....

Treatment: **CMF** ☐
or
Epi + CMF ☐

Date of Randomisation _____/_____/_____ **Date Last Seen** _____/_____/_____

Please fill in the following as appropriate:

Date of First Locoregional Recurrence	___/___/____	**Site**	
Date of First Distant Recurrence	___/___/___	**Site**	
Date of Second Primary	___/___/___	**Site**	
Date of Death	___/___/___	**Cause**	

Is the patient receiving tamoxifen (Y/N)? _____ **Dose per day** _____**mg**

What date was it first prescribed? _____/_____/_____

Has the patient suffered any thromboembolic events (Y/N)? _____ **(give details below)**

COMMENTS. Please give details of any serious adverse events, dates and reasons for any hospital admissions, the name of the Doctor responsible for the patient if they are no longer in your care and any other relevant information…….

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Signed: ..... **Date:** ____/____/____