

**NEAT TRIAL****DEATH REPORT FORM**Trial No. Treatment: CMF ☐  
or  
Epi + CMF ☐

Date of Randomisation

Patient Name: .....  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Hospital: .....  
Hospital No.: .....  
Consultant: .....**Please complete the following:**

|                                       |                      |      |                      |
|---------------------------------------|----------------------|------|----------------------|
| Date of First Locoregional Recurrence | <input type="text"/> | Site | <input type="text"/> |
| Date of First Distant Recurrence      | <input type="text"/> | Site | <input type="text"/> |
| Date of Second Primary                | <input type="text"/> | Site | <input type="text"/> |

Date of Death  Place of Death (Use Codes) \_\_\_\_\_  
1 = Home, 2 = Hospital, 3 = Hospice,  
4 = Abroad, 9 = UnknownDiagnosed Cause of Death.....  
.....Date of last chemotherapy treatment What cycle and part (Day 1 or Day 8) of the treatment was this (eg cycle 2, day 8).....  
.....

Did the patient receive tamoxifen (Y/N)? \_\_\_\_\_ Dose per day \_\_\_\_\_ mg

What date was it first prescribed? 

Did the patient suffer any thromboembolic events (Y/N)? \_\_\_\_\_ (give details below)

Please describe any symptoms the patient experience and give any other details you feel may be relevant.....  
.....  
.....

Signed: ..... Date: \_\_\_\_/\_\_\_\_/\_\_\_\_