

Name – patient ID <div style="text-align: center; margin-top: 10px;"> <table style="margin: auto; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: none; padding: 0 5px;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: none; padding: 0 5px;">-</td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> <td style="border: 1px solid black; width: 20px; height: 20px; display: inline-block;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">Day</td> <td></td> <td></td> <td style="text-align: center; font-size: small;">Month</td> <td></td> <td></td> <td style="text-align: center; font-size: small;">Year</td> <td></td> <td></td> <td style="text-align: center; font-size: small;">No.</td> </tr> </table> </div>			-			-					Day			Month			Year			No.	Hospital, department
		-			-																
Day			Month			Year			No.												
Date of off study: _____ <div style="text-align: center; font-size: x-small; margin-top: 5px;"> _____ day _____ month _____ year </div>																					
Cause of off study: <input type="checkbox"/> Withdrawal from follow-up <input type="checkbox"/> Recurrence (or contralateral invasive breast cancer, specify site(s) below) <input type="checkbox"/> Other malignant disease <input type="checkbox"/> Death																					
Localization of recurrence: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Lymph nodes, axillary, ipsilateral <input type="checkbox"/> Lymph nodes, axillary, contralateral <input type="checkbox"/> Lymph nodes, supraclavicular, ipsilateral <input type="checkbox"/> Lymph nodes, infraclavicular, ipsilateral <input type="checkbox"/> Lymph nodes, supraclavicular, contralateral <input type="checkbox"/> Lymph nodes, infraclavicular, contralateral <input type="checkbox"/> Lymph nodes, neck, ipsilateral <input type="checkbox"/> Lymph nodes, neck, contralateral <input type="checkbox"/> Lymph nodes, intrathoracale <input type="checkbox"/> Cicatrice </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Residual mamma <input type="checkbox"/> Contralateral mamma <input type="checkbox"/> Skin (outside regio mammalis) <input type="checkbox"/> Bones <input type="checkbox"/> Lungs <input type="checkbox"/> Pleural <input type="checkbox"/> Liver <input type="checkbox"/> Abdomen (other than liver) <input type="checkbox"/> CNS <input type="checkbox"/> Other (specify) _____ </td> </tr> </table>		<input type="checkbox"/> Lymph nodes, axillary, ipsilateral <input type="checkbox"/> Lymph nodes, axillary, contralateral <input type="checkbox"/> Lymph nodes, supraclavicular, ipsilateral <input type="checkbox"/> Lymph nodes, infraclavicular, ipsilateral <input type="checkbox"/> Lymph nodes, supraclavicular, contralateral <input type="checkbox"/> Lymph nodes, infraclavicular, contralateral <input type="checkbox"/> Lymph nodes, neck, ipsilateral <input type="checkbox"/> Lymph nodes, neck, contralateral <input type="checkbox"/> Lymph nodes, intrathoracale <input type="checkbox"/> Cicatrice	<input type="checkbox"/> Residual mamma <input type="checkbox"/> Contralateral mamma <input type="checkbox"/> Skin (outside regio mammalis) <input type="checkbox"/> Bones <input type="checkbox"/> Lungs <input type="checkbox"/> Pleural <input type="checkbox"/> Liver <input type="checkbox"/> Abdomen (other than liver) <input type="checkbox"/> CNS <input type="checkbox"/> Other (specify) _____																		
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Recurrence verified: <input type="checkbox"/> Yes, histological <input type="checkbox"/> Yes, cytological <input type="checkbox"/> No																					
Date:	Signature:																				