RECURRENCE FORM

Form 7

INSTRUCTIONS: Please complete this form in case of a recurrence and send it to IKNL clinical research department trialbureau@iknl.nl

Patient seqnr.
|__|__|__|__|__|-|__|__|__|__| **Hospital:** …… **Physician:**……

RECURRENCE

Date of diagnosis of (re)recurrence ..... |__|__||__|__||__|__|__|__|

Number of recurrence..... |__|

Nature of recurrence **#1**	Diagnosed by **#2**	Treated **(0=No, 1=Yes)**	Date of treatment **(dd/mm/yyyy)**	Type of treatment
|__|__|	|__|	|__|	|__|__||__|__||__|__|__|__|	……..
|__|__|	|__|	|__|	|__|__||__|__||__|__|__|__|	……..
|__|__|	|__|	|__|	|__|__||__|__||__|__|__|__|	……..
|__|__|	|__|	|__|	|__|__||__|__||__|__|__|__|	……..
|__|__|	|__|	|__|	|__|__||__|__||__|__|__|__|	……..

#1 Nature of recurrence: 1= local, Specify exact location ..... , 2= liver, 3= lung
4= trocar wound, 5= minilaparotomy wound, 6= laparotomy wound, 7= lymph nodes, 8= brain metastasis, 9= bone metastasis, 10= other, specify.....

#2 Recurrence diagnosed by: 1=CT, 2=MRI, 3=colonoscopy, 4=PET, 5=Ultrasound, 6=Chest X-ray, 7=Other, specify .....

Intention treatment: Curative/Palliative (0 = Curative, 1 = Palliative) ..... |__|

COMMENTS

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Date:…….. ..... **Investigator's signature:**……