TNO: ☐☐☐☐ **Initials:** ☐☐☐

Please complete and enter this information post randomisation.

5.1 TUMOUR PATHOLOGY

1. Date of diagnosis *(defined by date of first positive biopsy)* d d – m o n – y y y y

2. Date of surgery *(date of main tumour excision)* d d – m o n – y y y y

3. Type of surgery *(please tick all that apply)*

- ☐ Local excision/ lumpectomy
- ☐ Mastectomy
- ☐ **Mastectomy with Reconstruction**
- ☐ **Sentinel Node Biopsy**
- ☐ Axillary sample
- ☐ Axillary clearance

4. Tumour ER status *(Please complete at least one of these sections)*

Please complete one section

If only % staining was reported:

% stained cells: ☐☐☐ (0—100)

If ER was reported as Allred score:

Allred (Quick) Score: ☐ (0, 2 - 8)

N.B. An Allred / quick score of 8 always equates to 67-100%

% stained cells (tick one):

<1% ☐ 1-10% ☐ 11-33% ☐ 34-66% ☐ 67-100% ☐

If ER was reported as H-score:

H-score: ☐☐☐ (0—300)

% stained cells: ☐☐☐ (0—100)

5. Tumour grade

- ☐ Grade 1/ Low grade
- ☐ Grade 2/ Intermediate grade
- ☐ Grade 3/ High grade

6. Final TNM staging

T: 1, 2, 3 or 4 ☐ *(if T0 or Tx review eligibility)*

N: 0, 1, 2 or 3 ☐

M: 0 or x ☐ *(if M1 review eligibility)*

5.2 BREAST CANCER TREATMENT

1. Did the participant receive neo-adjuvant chemotherapy?

- ☐ Yes
- ☐ No

2. Did the participant receive adjuvant chemotherapy?

- ☐ Yes
- ☐ No

3. Has the participant been prescribed anti-HER2 therapy?

- ☐ Yes → Date started: d d – m o n – y y y y
- ☐ No

TNO: ☐☐☐☐ Initials: ☐☐☐

4. Has the participant been prescribed, or are they planned to receive a CDK4/6 inhibitor such as Abemaciclib or Ribociclib?

☐ Yes → Date **prescribed:** d d – m o n – y y y y

☐ CDK4/6i planned but not yet **received**

☐ No

5. Has the participant been prescribed bisphosphonates (oral or IV)?

N.B. If the exact date is unknown because the prescription was started by the GP, please record the date the GP was first instructed to prescribe this from the hospital.

☐ Yes (Please detail below) →

☐ No

Date **prescribed** (DD/MON/YYYY)	Drug name	Route
	☐ Zolendronic acid ☐ Ibradronic acid ☐ Other *(please detail below)* ☐	☐ Oral ☐ IV

6. Has the participant received ovarian suppression?

☐ Yes *(Please provide details)* →

☐ No

N.B. If the exact date is unknown because the prescription was started by the GP, please record the date the GP was first instructed to prescribe this from the hospital.

Date **prescribed** (DD/MON/YYYY)	Type of ovarian suppression
☐	Surgical
☐	Medical (i.e. GNRH agonist)

7. Has the participant received, or are they planned to receive radiotherapy?

☐ Yes, radiotherapy received

☐ Radiotherapy planned but not yet started

☐ No

5.3 ENDOCRINE THERAPY DETAILS

N.B. If the exact date is unknown because the prescription was started by the GP, please record the date the GP was first instructed to prescribe this from the hospital.

1. Which adjuvant hormone therapy is the participant currently taking?

Date **prescribed** (DD/MON/YYYY)	Endocrine therapy	Who issued the prescription?	Total intended duration *(years)*
	☐ Tamoxifen ☐ Letrozole ☐ Anastrozole ☐ Exemestane ☐ Other (please detail) ☐	☐ Consultant/ Hospital led ☐ GP	

TNO: ☐☐☐☐ **Initials:** ☐☐☐

2. Since adjuvant hormone therapy was first prescribed, have there been any changes to the prescription?

☐ Yes *(Please provide details below)*
☐ No *(Please skip to question 5.3.3)*

Date **prescribed** (DD/MON/YYYY)	Date stopped (DD/MON/YYYY)	Previous endocrine therapy	Reason for drug change
		☐ Tamoxifen ☐ Letrozole ☐ Anastrozole ☐ Exemestane ☐ Other *(please detail below)*	☐ Toxicity ☐ Other *(please detail below)*
		☐ Tamoxifen ☐ Letrozole ☐ Anastrozole ☐ Exemestane ☐ Other *(please detail below)*	☐ Toxicity ☐ Other *(please detail below)*

3. Did the participant receive neo-adjuvant endocrine therapy?

☐ Yes *(Please provide details below)*
☐ No *(Please skip to question 5.3.4)*

Date **prescribed** (DD/MON/YYYY)	Date stopped (DD/MON/YYYY)	Neo-adjuvant endocrine therapy
		☐ Tamoxifen ☐ Letrozole ☐ Anastrozole ☐ Exemestane ☐ Other *(please detail below)*

4. Has the participant had a previous breast cancer?

☐ Yes
☐ No

Form completed by

Printed name: Signature: Date signed:

d d – m o n – y y y y

N.B. The individual named must be on the delegation log with the assigned responsibility for CRF completion.