Physician Follow-up Form - Version 1.0

This ___ month Physician Follow-up Form is mailed to patients who are asked to bring it to their next doctor's appointment for care of their brain tumor. This form is completed at 3-month intervals following the enrollment surgery.

Physician Information

Neurosurgeon _____ _____
First Name Last Name

Hospital / Clinic _____

The physician completing this form is

Physician _____ _____
First Name Last Name

Specialty ☐ Neurosurgeon ☐ Neuro-oncologist ☐ Neuro-radiologist ☐ Internist ☐ Other _____

Hospital / Clinic _____

Address _____

City _____ State _____ Zip / Postal Code _____ - _____

Telephone Number (__ __ __) __ __ __ - __ __ __ __ Fax Number (__ __ __) __ __ __ - __ __ __ __

Patient Information

Patient Name: _____

Social Security Number: _____ (or Social Insurance Number in Canada)

1. Date of Completion (Today's Date)

__ __ / __ __ / __ __
month / day / year

2. Compared to the last set of imaging studies, the current imaging studies show the tumor is

☐ Not present
☐ Smaller
☐ Unchanged
☐ Larger
☐ Study not done

3. Karnofsky Performance Score (most recent score - within the past 3-months)

__ __ __ (Range 0 - 100)

4. Morbid events (within the <u>past 3 months</u>)

	Yes	No	Unknown
Depression	☐	☐	☐
Deep vein thrombosis	☐	☐	☐
Intracranial hemorrhage	☐	☐	☐
Pulmonary embolism	☐	☐	☐
Systemic infection	☐	☐	☐
Seizure	☐	☐	☐
Wound infection	☐	☐	☐
Gastrointestinal ulcer	☐	☐	☐
Hydrocephalus	☐	☐	☐
Cognitive impairment	☐	☐	☐
Steroid induced diabetes	☐	☐	☐
Steroid myopathy	☐	☐	☐
Adverse drug reaction	☐	☐	☐
Specify_____			
Other	☐	☐	☐
Specify_____			

5. Medications (within the <u>past 3 months</u>)

	Yes	No	Unknown
Anticonvulsants	☐	☐	☐
Antidepressants	☐	☐	☐
Specify_____			
Antipsychotics	☐	☐	☐
Specify_____			
Other	☐	☐	☐
Specify_____			

6. Current glucocorticosteroid use

☐ None
☐ Stable dose
☐ Escalating dose
☐ Decreasing dose
☐ Unknown

7. Adjuvant therapy (within the <u>past 3 months</u>)

	Yes	No	Unknown
Systemic chemotherapy	☐	☐	☐
External beam radiation therapy	☐	☐	☐
Brachytherapy	☐	☐	☐
Stereotactic radiosurgery	☐	☐	☐
Stereotactic radiotherapy	☐	☐	☐
Other	☐	☐	☐
Specify_____			

8. Complications of therapy (within the <u>past 3 months</u>)

	Yes	No	Unknown	N/A
Systemic chemotherapy	☐	☐	☐	☐
External beam radiation therapy	☐	☐	☐	☐
Brachytherapy.	☐	☐	☐	☐
Stereotactic radiosurgery	☐	☐	☐	☐
Stereotactic radiotherapy	☐	☐	☐	☐
Other	☐	☐	☐	☐
Specify_____				

9. Has the patient been enrolled in a formal clinical brain tumor trial within the <u>past 3 months</u>?

☐ Yes (Specify _____)
☐ No
☐ Unknown

10. Treatment plan

	Yes	No
Craniotomy	☐	☐
Carmustine wafer implant	☐	☐
Systemic chemotherapy	☐	☐
External beam radiation therapy	☐	☐
Brachytherapy	☐	☐
Stereotactic radiosurgery	☐	☐
Stereotactic radiotherapy	☐	☐
Observation	☐	☐
Hospice	☐	☐
Other	☐	☐
Specify_____		

12. Comments (other treatments, etc.)

_____
_____
_____
_____
_____
_____

Thank You for Completing This Questionnaire

Please return the completed form in the envelope provided. If you lose the envelope and want another, call 1-888-820-7171. Our address is

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