This form must be completed every six months during the first two years from the date of first treatment, and every twelve months thereafter for a total of 5 years (i.e., 60 months).
1. Patient Profile

- Surname: .................................................................
- Given Name: ...........................................................
- OHIN: ................................................................. • Chart Number: ..........................................................
- Postal Code: ........................................................
- Height (cm): ......................................................... • Weight (kg): ......................................................
- BSA (m²): .............................................................. • Gender:  
  □ Male  □ Female  □ Other
- Date of Birth: ....................................................... Day Month Year
- Site:
- Attending Physician (MRP- Most Responsible Physician): .................................................................

2. Questions

  a. This supplemental form is being submitted for the __th month following the patient's first treatment.  
  □ 6  □ 12  □ 18  □ 24  
  □ 36  □ 48  □ 60

  b. Is the patient alive?  
  □ Yes  □ No

  c. Date of death: ....................................................... Day Month Year

  d. Cause(s):  
  □ Breast cancer  □ Other

  e. Is the patient disease free?  
  □ Yes  □ No

  f. Is there distant recurrence? (If distant recurrence was noted as “yes” on a previous supplemental form, please skip to question ‘h’)
  □ Yes  □ No  □ Previously Reported

  g. If yes, date of distant recurrence: ....................................................... Day Month Year

  h. Is there local recurrence (i.e., in the same breast)? (If local recurrence was noted as “yes” on a previous supplemental form, please skip to question ‘j’)
  □ Yes  □ No  □ Previously Reported

  i. If yes, date of local recurrence: ....................................................... Day Month Year

  j. Is there recurrence in the regional lymph nodes? (If regional lymph node recurrence was noted as “yes” on a previous
  □ Yes  □ No  □ Previously Reported
LVEF at 3 months post trastuzumab treatment start date

<table>
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<tr>
<th>Test Method</th>
<th>MUGA</th>
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<th>LVEF not done</th>
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</thead>
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LVEF at 6 months post trastuzumab treatment start date

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<tr>
<td>Value</td>
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LVEF at 9 months post trastuzumab treatment start date

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LVEF at 12 months post trastuzumab treatment start date

Test Method
- [ ] MUGA
- [ ] ECHO
- [ ] LVEF not done

Date of Test
----------  ----------  ----------
Day  Month  Year

Value
----------

LVEF at 24 months post trastuzumab treatment start date

Test Method
- [ ] MUGA
- [ ] ECHO
- [ ] LVEF not done

Date of Test
----------  ----------  ----------
Day  Month  Year

Value
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4. Notes

As a condition of participating in EBP trastuzumab, supplemental forms are required and must be submitted as follows:
- Every six months during the first two years from the date of first treatment
- Every twelve months thereafter for a total of 5 years (i.e., 60 months)

Signature of Attending Physician

(MRP- Most Responsible Physician):

18  11  2015
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Day  Month  Year