Baseline Form

Date	D	D	M	M	M	Y	Y	Y	Y

Assessor Name	

Participant ID					-			

Participant Initials			

Trial Manager
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Date Informed Consent completed:

D	D	/	M	M	M	/	Y	Y	Y	Y

Date Eligibility confirmed:

D	D	/	M	M	M	/	Y	Y	Y	Y

Date: | | | | | | | | | ID: | | | | | - | | | | Initials: | | | |

MANCAN2: Baseline Form – Nurse Reported Section

Please refer to the patient's medical notes when completing sections A – D.

Section A- Prostate Cancer Diagnosis Details

1. Date of Diagnosis: | D | D | M | M | M | Y | Y | Y | Y |

2. Does the patient have a localised (M0) or advanced (M1) diagnosis?
   Localised ☐ Advanced ☐

3. Please indicate the treatment intent for this patient:
   Curative ☐ Palliative ☐

Section B- current use of hormone therapies- ADT

Please indicate the type of Androgen Deprivation Therapy (ADT) that the patient is <u>currently</u> receiving. Please state the date the therapy started:

ADT Type	**Yes**	**No**	**If yes, date therapy started**
LHRH analogue	Y	N	D D / M M M / Y Y Y Y
LHRH antagonist	Y	N	D D / M M M / Y Y Y Y
Surgical castration (date procedure conducted)	Y	N	D D / M M M / Y Y Y Y

Eligibility note: a minimum <u>of 4 months</u> must have elapsed between the start date of ADT and todays date, in order for the patient to be eligible for mancan2.

If the patient is receiving LHRH analogue or LHRH antagonist ADT, what is the planned frequency for the injection administration:

Once a month ☐ 3-monthly ☐ 6-monthly ☐ Other: _____

If the patient is receiving LHRH analogue or LHRH antagonist ADT, what is the planned remaining treatment duration:

Number of Months: _____ Permanent ☐

Eligibility note: planned remaining treatment duration must be a <u>minimum of 12 months</u> continuous treatment, in order for the patient to be eligible for mancan2.

Section C- current use of *other* hormone therapies

Please indicate whether the patient is <u>currently</u> using **antiandrogen therapies** in combination with ADT:

Abiraterone (Zytiga)	Y	N
Enzalutamide (Xtandi)	Y	N
Darolutamide (Nubeqa)	Y	N
Apalutamide (Erleada)	Y	N
Bicalutamide (Casodex)	Y	N

Other: _____

Please indicate whether this patient is <u>currently</u> receiving a **bisphosphonate** such as alendronate, *ibandronate*, risedronate or zoledronate (e.g. *Binosto, Fosamax, Boniva, Actonel, Atelvia, Reclast, Zometa*) or denosumab (*Xgeva*):

Yes☐ No ☐

Section D - prior prostate cancer therapies

Please indicate whether the patient has <u>historically</u> received any of the cancer therapies listed below:

			<u>If Yes (to items a,b, c or d) , please detail the Treatment **End Date**</u>
a) Prostate external beam radiotherapy*	Y	N	D D / M M M / Y Y Y Y
b) Prostate brachytherapy*	Y	N	D D / M M M / Y Y Y Y
c) Prostate focal ablation therapy*	Y	N	D D / M M M / Y Y Y Y
d) Chemotherapy**	Y	N	D D / M M M / Y Y Y Y
e) Prostatectomy	Y	N	
f) Radiotherapy to other sites beyond the prostate itself	Y	N	

Other: _____

Eligibility note: If the patient has received multi-fraction external beam radiotherapy, brachytherapy or focal ablation techniques, **<u>a minimum of 6 weeks</u> must have elapsed between the date of the final fraction/treatment and todays date in order for the patient to be eligible for mancan2.*

Date: ☐☐☐☐☐☐☐☐ ID: ☐☐☐☐-☐☐☐ Initials: ☐☐☐

***If the patient has received chemotherapy, **a minimum of 3 months must have** elapsed between the date of the final dose and today's date in order for the patient to be eligible for mancan2.*

MANCAN2: Baseline Form – Patient Reported Section

Please call the patient to collect the information for this section (section E). Please summarise the information that you have provided on this form (in sections A-D) with the patient.

Section E- Current treatment for HFNS symptoms

Please indicate whether the patient is currently using any of the following. If 'yes', please specify whether the patient is using them to treat their HFNS symptoms (HFNS) or whether they are using them for another reason (Other). If the patient is using them for both their HFNS and Other, then please tick 'Both'.

	Yes	No	HFNS	Other	Both
Medroxyprogesterone Acetate	☐	☐	☐	☐	☐
Megestrol Acetate	☐	☐	☐	☐	☐
Cyproterone Acetate	☐	☐	☐	☐	☐
Gabapentin	☐	☐	☐	☐	☐
Clonidine	☐	☐	☐	☐	☐
Venlafaxine	☐	☐	☐	☐	☐
Paroxetine	☐	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐	☐
Hypnotherapy	☐	☐	☐	☐	☐
Herbal Remedies*	☐	☐	☐	☐	☐
Homeopathic	☐	☐	☐	☐	☐

Other: _____

*If the patient is using **Herbal Remedies** please specify the type:

Date: ☐☐☐☐☐☐☐☐ ID: ☐☐☐☐-☐☐☐ Initials: ☐☐☐

Is the patient eligible for mancan2? **Yes ☐ No ☐**

SIGNATURE:

PRINT NAME:

DATE: D D/ M M M / Y Y Y Y

Thank you. Please return this form to the Research Team at SCTU using University of Southampton safesend.

To use Safesend

1. Go to safesend.soton.ac.uk
2. Click the 'Drop-off button' and complete the required fields (your name, organisation and your work email address). SafeSend will send an email to your email with a link for you to follow. Follow the link.
3. Add the name: mancan2 and email mancan2@soton.ac.uk as your recipient. Click 'Add'. Then drag or click to add your contacts form, add a message if you like, then click 'drop-off files'. This will send your contacts form securely to the research team at SCTU.