Supplemental File

'ADVANCE' (A Pilot Trial) ADjuVANt Chemotherapy in the Elderly:

Developing and Evaluating Lower-Toxicity Chemotherapy Options for Older Patients with Breast Cancer

- **Supplemental Table S1: Cohorts 1 and 2 Treatment Administration**
- **Patient And Clinician Surveys**

Supplemental Table S1. Cohorts 1 and 2 Treatment Administration

COHORT 1											
Case ID	**carboplatin**				**paclitaxel**				**Feasibility met?**	**Total duration (weeks) of therapy, including holds**	
	Carboplatin doses given	*# of dose holds*	*# of dose reductions*	*Feasible per carboplatin?*	*Paclitaxel doses given*	*# of doses held*	*# of dose reductions*	*Feasible per paclitaxel*	*Feasible for both?*	*Carboplatin* [a]	*Paclitaxel* [a]
1	12	1	1	Yes	12	1	.	Yes	Yes	12	12
2	9	1	1		9	1	1			10	10
6	12	.	.	Yes	12	.	.	Yes	Yes	11	11
7	11	1	.	Yes	11	1	.	Yes	Yes	11	11
8	6	.	1		6	.	.			5	5
11	9	1	1		9	1	1			8	8
12	12	.	.	Yes	12	.	.	Yes	Yes	11	11
16	9	3	2		11	1	1	Yes		11	11
17	12	2	1	Yes	12	2	1	Yes	Yes	14	14
18	12	.	2	Yes	9	1	1			15	15
19	12	1	.	Yes	10	4	1			12	12
20	8	2	.		6	4	1			10	10
23	10	5	.		10	5	.			15	15
24	12	4	.	Yes	12	4	1			15	15
25	9	2	1		9	2	2			10	10
32	12	2	1	Yes	12	2	2	Yes	Yes	14	14
34	12	1	1	Yes	12	1	1	Yes	Yes	12	12
35	8	1	.		12	1	.	Yes		13	13
39	10	5	1		10	5	4			14	14
41	12	2	2	Yes	12	2	2	Yes	Yes	14	14
COHORT 2											
Case ID	**Cyclophosphamide**				**paclitaxel**					**Total duration (weeks) of therapy, including holds**	
	Cyclophosphamide doses given	*# of dose holds*	*# of dose reductions*	*Feasible per cyclophosphamide?*	*Paclitaxel doses given*	*# of doses held*	*# of dose reductions*	*Feasible per paclitaxel*	*Feasible for both?*	*cyclophosphamide*	*paclitaxel*
3	4	.	.	Yes	12	.	.	Yes	Yes	11	11
4	4	.	.	Yes	12	.	.	Yes	Yes	11	11
5	4	.	.	Yes	11	2	1	Yes	Yes	12	12
10	4	.	.	Yes	12	2	1	Yes	Yes	13	13
13	4	.	1	Yes	10	1	1	Yes	Yes	10	10
14	4	.	.	Yes	12	.	.	Yes	Yes	11	11
15	4	.	.	Yes	12	.	.	Yes	Yes	11	11

21	4	.	.	Yes	12	.	.	Yes	Yes	11	11
22	4	.	1	Yes	10	3	1		No	12	12
26	3	.	.	Yes	8	1	.		No	9	9
27	4	.	.	Yes	12	1	.	Yes	Yes	12	12
28	2	.	.		4	2	1		No	4	4
29	4	.	2		9	3	.		No	11	11
30	4	1	.	Yes	11	3	1		No	15	16
31	4	1	.	Yes	5	.	.		No	10	10
33	4	.	.	Yes	11	2	2		No	12	12
36	1	.	.		1	.	.		No	0	0
37	4	.	3		12	2	3		No	16	16
38	4	.	1	Yes	10	4	1		No	13	13
40	4	.	.	Yes	12	1	1	Yes	Yes	12	12

[a] Weeks were rounded up or down to the nearest whole number

PATIENT AND CLINICIAN SURVEYS

PATIENT SURVEY – GERIATRIC ASSESSMENT (GA)

Note: demographics were asked at baseline only. Other components were asked each time the GA is administered.

DEMOGRAPHICS

We would like to know a bit more details about you so we know about the characteristics of people participating in the study. You may skip any questions you prefer not to answer but we assure you this is for demographics only and your answers will be kept completely confidential.

1. What is the highest grade you finished in school? *(Mark one with an X.)*

☐ Less than 9 years of school	☐ Some college or technical school	☐ Post graduate education, but no higher degree
☐ Some high school (9-11 years)	☐ College degree graduate	
☐ High school graduate, or GED	☐ Graduate degree	☐ I prefer not to answer

2. What is your marital status? *(Mark one with an X.)*

☐ Married	☐ Divorced	□ I prefer not to answer
☐ Domestic partnership	☐ Separated	
☐ Widowed	☐ Never married	

3. With whom do you live? *(Mark all that apply with an X.)*

☐ Spouse / partner	☐ Parents/ parents-in-law
☐ Girlfriend / boyfriend	☐ Live alone
☐ Children aged 18 years or younger	☐ Others, specify: _____
☐ Children aged 18 years or older	☐ Other relative, specify: _____

4. What is your current employment status? *(Mark one with an X)*

☐ Employed ≥ 32 hours per week
☐ Employed ≤ 32 hours per week
☐ Homemaker
☐ Disabled
☐ On medical leave
☐ Unemployed
☐ Retired
☐ Student full-time
☐ Student part-time
☐ Other, specify: _____

5. What is your current annual household income? Is it…

☐<$20,000
☐$20-40,000
☐$41-60,000
☐$61-80,000
☐$81-100,000
☐ more than $100,000
☐ I prefer not to answer

6. In what country were you born?
   - o US
   - o Other _____

7. Do you consider yourself to be Hispanic or Latina? Hispanic, Spanish, or Latina is a person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture of origin, regardless of race.
   - ☐ Yes
   - ☐ No
   - ☐ Other_____

8. Which of the following would you use to describe yourself? Would you describe yourself as…
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ American Indian or Alaska Native

- ☐ Asian
- ☐ Black or African American
- ☐ White
- ☐ more than one of these?
- ☐ Other (write in) _____

DAILY ACTIVITIES

Indicate your response by marking an X in one box per question.

1. Can you use the telephone…

☐ without help, including looking up and dialing;
☐ with some help (can answer phone or dial operator in an emergency, but need a special phone or help in getting the phone number or dialing); or
☐ are you completely unable to use the telephone?

2. Can you get to places out of walking distance…

☐ without help (can travel alone on buses, taxis, or drive your own car);
☐ with some help (need someone to help you or go with you when traveling); or
☐ are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?

3. Can you go shopping for groceries or clothes (assuming you have transportation)…

☐ without help (taking care of all shopping needs yourself, assuming you have transportation);
☐ with some help (need someone to go with you on all shopping trips); or
☐ are you completely unable to do any shopping?

4. Can you prepare your own meals…

☐ without help (plan and cook full meals yourself);

☐ with some help (can prepare some things but unable to cook full meals yourself) ; or
☐ are you completely unable to prepare any meals?

5. Can you do your housework…

☐ without help (can clean floors, etc);
☐ with some help (can do light housework but need help with heavy work); or
☐ are you completely unable to do any housework?

6. Can you take your own medicines…

☐ without help (in the right doses at the right time);
☐ with some help (able to take medicine if someone prepares it for you and/or reminds you to take it); or
☐ are you completely unable to take your medicines?

7. Can you handle your own money…

☐ without help (write checks, pay bills, etc.);
☐ with some help (manage day-to-day buying but need help with managing your checkbook and paying your bills); or
☐ are you completely unable to handle money?

PHYSICAL ACTIVITIES

1. The following items are activities you might do during a typical day. Does your health limit you in these activities? **(*Mark an X in the box on each line that best reflects your situation.*)**

Activities	Limited a lot	Limited a little	Not limited at all
A. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	☐1	☐2	☐3
B. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	☐1	☐2	☐3

Activities	Limited a lot	Limited a little	Not limited at all
C. Lifting or carrying groceries	☐1	☐2	☐3
D. Climbing several flights of stairs	☐1	☐2	☐3
E. Climbing one flight of stairs	☐1	☐2	☐3
F. Bending, kneeling, or stooping	☐1	☐2	☐3
G. Walking more than a mile	☐1	☐2	☐3
H. Walking several blocks	☐1	☐2	☐3
I. Walking one block	☐1	☐2	☐3
J. Bathing or dressing yourself	☐1	☐2	☐3

CURRENT HEALTH RATING*

Which one of the following phrases best describes you at this time? *(Mark one with an X.)*

☐ Normal, no complaints, no symptoms of disease
☐ Able to carry on normal activity, minor symptoms of disease
☐ Normal activity with effort, some symptoms of disease
☐ Care for self, unable to carry on normal activity or do active work
☐ Require occasional assistance but able to care for most of personal needs
☐ Require considerable assistance for personal care
☐ Disabled, require special care and assistance
☐ Severely disabled, require continuous nursing care

FALLS

How many times have you fallen in the last 6 months? _____

YOUR HEALTH

1. Your General Health*****

Patient Instructions: Do you have any of the following illnesses at the present time, and if so, how much does it interfere with your activities: **Not at All, A Little or A Great Deal?** *(Mark an X in the box that best reflects your answer.)*

		If you have this illness: How much does it interfere with your activities?			
Illness	**No**	**Yes**		**Not at all**	**A little**	**A great deal**
A. Other cancers or leukemia	☐	☐	→	☐	☐	☐
B. Arthritis or rheumatism	☐	☐	→	☐	☐	☐
C. Glaucoma	☐	☐	→	☐	☐	☐
D. Emphysema or chronic bronchitis	☐	☐	→	☐	☐	☐
E. High blood pressure	☐	☐	→	☐	☐	☐
F. Heart trouble	☐	☐	→	☐	☐	☐
G. Circulation trouble in arms or legs	☐	☐	→	☐	☐	☐
H. Diabetes	☐	☐	→	☐	☐	☐
I. Stomach or intestinal disorders	☐	☐	→	☐	☐	☐
J. Osteoporosis	☐	☐	→	☐	☐	☐

Illness	No	If you have this illness: How much does it interfere with your activities? Yes		Not at all	A little	A great deal
K. Liver disease	☐	☐	→	☐	☐	☐
L. Kidney disease	☐	☐	→	☐	☐	☐
M. Stroke	☐	☐	→	☐	☐	☐
N. Depression	☐	☐	→	☐	☐	☐

2. How is your eyesight (with glasses or contacts)? *(Mark one with an X.)*

   ☐1 Excellent
   ☐2 Good
   ☐3 Fair
   ☐4 Poor
   ☐5 Totally blind

3. How is your hearing (with a hearing aid, if needed)? *(Mark one with an X.)*

   ☐1 Excellent
   ☐2 Good
   ☐3 Fair
   ☐4 Poor
   ☐5 Totally deaf

4. Do you have any other physical problems or illnesses (other than listed in questions 1-4) at the present time that seriously affect your health?

☐ No
☐ Yes, specify: _____

If yes, how much does this interfere with your activities? *(Mark one with an X.)*

☐ Not at all ☐ Somewhat ☐ A great deal

5. How many medications (either prescribed or over-the-counter), herbs, or vitamins do you currently take? _____

Please list all prescribed or over-the-counter medicines, herbs, or vitamins you are currently taking (doses not necessary).

HEALTH QUESTIONNAIRE*

INSTRUCTIONS: These questions are about how you have been feeling within the past month. Please mark an "X" in the box on each line that best reflects your situation.

How much of the time during the past month:	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
1. has your daily life been full of things that were interesting to you?	☐1	☐2	☐3	☐4	☐5	☐6
2. did you feel depressed?	☐1	☐2	☐3	☐4	☐5	☐6
3. have you felt loved and wanted?	☐1	☐2	☐3	☐4	☐5	☐6
4. have you been a very nervous person?	☐1	☐2	☐3	☐4	☐5	☐6
5. have you been in firm control of your behavior, thoughts, emotions, feelings?	☐1	☐2	☐3	☐4	☐5	☐6
6. have you felt tense or high-strung?	☐1	☐2	☐3	☐4	☐5	☐6

How much of the time during the past month:	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
7. have you felt calm and peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
8. have you felt emotionally stable?	☐1	☐2	☐3	☐4	☐5	☐6
9. have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6
10. have you felt restless, fidgety, or impatient?	☐1	☐2	☐3	☐4	☐5	☐6
11. have you been moody, or brooded about things?	☐1	☐2	☐3	☐4	☐5	☐6
12. have you felt cheerful, light-hearted?	☐1	☐2	☐3	☐4	☐5	☐6
13. have you been in low or very low spirits?	☐1	☐2	☐3	☐4	☐5	☐6
14. were you a happy person?	☐1	☐2	☐3	☐4	☐5	☐6
15. did you feel you had nothing to look forward to?	☐1	☐2	☐3	☐4	☐5	☐6
16. have you felt so down in the dumps that nothing could cheer you up?	☐1	☐2	☐3	☐4	☐5	☐6
17. have you been anxious or worried?	☐1	☐2	☐3	☐4	☐5	☐6

SOCIAL ACTIVITIES

1. During the past 4 weeks, how much time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? *(Mark one with an X.)*

☐ 1 All of the time
☐ 2 Most of the time
☐ 3 Some of the time
☐ 4 A little of the time
☐ 5 None of the time

2. Compared to your usual level of social activity, has your social activity during the past 6 months decreased, stayed the same, or increased because of a change in your physical or emotional condition? *(Mark one with an X.)*

   ☐ 1 Much less socially active than before
   ☐ 2 Somewhat less socially active than before
   ☐ 3 About as socially active as before
   ☐ 4 Somewhat more socially active as before
   ☐ 5 Much more socially active than before

3. Compared to others your age, are your social activities more or less limited because of your physical health or emotional problems? *(Mark one with an X.)*

   ☐ 1 Much more limited than others
   ☐ 2 Somewhat more limited than others
   ☐ 3 About the same as others
   ☐ 4 Somewhat less limited than others
   ☐ 5 Much less limited than others

SOCIAL SUPPORT*

INSTRUCTIONS: People sometimes look to others for companionship, assistance or other types of support. How often is each of the following kinds of support available to you if you need it? (*Mark an X in the box on each line that best reflects your situation.*)

	None of the Time	**A Little of the Time**	**Some of the Time**	**Most of the Time**	**All of the Time**

1. Someone to help you if you were confined to bed.	☐1	☐2	☐3	☐4	☐5
2. Someone you can count on to listen to you when you need to talk.	☐1	☐2	☐3	☐4	☐5
3. Someone to give you good advice about a crisis.	☐1	☐2	☐3	☐4	☐5
4. Someone to take you to the doctor if you needed it.	☐1	☐2	☐3	☐4	☐5
5. Someone to give you information to help you understand a situation.	☐1	☐2	☐3	☐4	☐5
6. Someone to confide in or talk to about yourself or your problem.	☐1	☐2	☐3	☐4	☐5
7. Someone to prepare your meals if you were unable to do it yourself.	☐1	☐2	☐3	☐4	☐5
8. Someone whose advice you really want.	☐1	☐2	☐3	☐4	☐5
9. Someone to help you with daily chores if you were sick.	☐1	☐2	☐3	☐4	☐5
10. Someone to share your most private worries and fears with.	☐1	☐2	☐3	☐4	☐5
11. Someone to turn to for suggestions about how to deal with a personal problem.	☐1	☐2	☐3	☐4	☐5
12. Someone who understands your problems.	☐1	☐2	☐3	☐4	☐5

SPIRITUALITY/RELIGION

Directions: Please answer the following questions about your religious beliefs and/or involvement. (Please mark an "X" in the box on each line that best reflects your situation.)

1. How often do you attend church or other religious meetings? *(Mark one with an X.)*

   ☐ 1 More than once/wk
   ☐ 2 Once a week

☐ 3 A few times a month
☐ 4 A few times a year
☐ 5 Once a year or less
☐ 6 Never

2. How often do you spend time in private religious activities, such as prayer, meditation or Bible study? *(Mark one with an X.)*

☐ 1 More than once a day
☐ 2 Daily
☐ 3 Two or more times/week
☐ 4 Once a week
☐ 5 A few times a month
☐ 6 Rarely or never

The following section contains 3 statements about religious belief or experience. Please mark the extent to which each statement is true or not true for you.

3. In my life, I experience the presence of the Divine (i.e., God). *(Mark one with an X.)*

☐ 1 Definitely true of me
☐ 2 Tends to be true
☐ 3 Unsure
☐ 4 Tends *not* to be true
☐ 5 Definitely *not* true

4. My religious beliefs are what really lie behind my whole approach to life. *(Mark one with an X.)*

☐ 1 Definitely true of me
☐ 2 Tends to be true
☐ 3 Unsure
☐ 4 Tends *not* to be true
☐ 5 Definitely *not* true

5. I tried hard to carry my religion over into all other dealings in my life. *(Mark one with an X.)*

   ☐ 1 Definitely true of me
   ☐ 2 Tends to be true
   ☐ 3 Unsure
   ☐ 4 Tends *not* to be true
   ☐ 5 Definitely *not* true

YOUR FEELINGS

1. Do you often feel sad or depressed?

   ☐ No ☐ Yes

2. How would you describe your level of anxiety, on the average?

Please circle the number (0-10) best reflecting your response to the following that describes your feelings **during the past week, including today**.

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
No anxiety										Anxiety as bad as it can be

GERIATRIC ASSESSMENT FOR THE HEALTH CARE PROFESSIONAL

I. This form completed by: ***(Mark all that apply with an X.)***

☐ Physician ☐ Nurse ☐ CRA

Assessment Period (as applicable to this study)

☐ Pre-treatment ☐☐ Cycle # ☐ End of Treatment

Mark box with an "X", if form was not completed at specified timepoint and specify reason:
(Mark one with an X.)

☐ Patient refused ☐ Patient withdrew consent ☐ Not done

☐ Other, specify _____

(For assessment date, record approximate date form was to be completed.)

II. FUNCTIONAL STATUS

A. KPS (Healthcare professional rated)

Please rate your assessment of patient's Karnofsky Performance Status as of date this form is completed. *(Scale is listed below.)*

☐☐☐ %

%	CRITERIA
100	Normal: no complaints; no evidence of disease
90	Able to carry on normal activity; only minor signs or symptoms of disease
80	Normal activity with effort; some signs or symptoms of disease
70	Cares for self, but unable to carry on normal activity or do active work
60	Requires occasional assistance, but is able to care for most personal needs
50	Requires considerable assistance and frequent medical care

40	Disabled; requires special care and assistance
30	Severely disabled; hospitalization is indicated although death not imminent
20	Very sick; hospitalization necessary; active supportive treatment necessary
10	Moribund; fatal processes progressing rapidly
0	Dead

B. Timed "Up and Go"

INSTRUCTIONS: The timed "Up and Go" measures, in seconds, the time it takes for an individual to stand up from a standard arm chair (approximate seat height of 46 cm [approximately 1.5 ft]), walk a distance of 3 meters (approximately 10 feet), turn, walk back to the chair, and sit down again. The subject wears his/her regular footwear and uses their customary walking aid (none, cane, walker, etc.) No physical assistance is given. The subject starts with his back against the chair, his arm resting on the chair's arm, and his walking aid in hand. He is instructed that on the word "go", he is to get up and walk at a comfortable and safe pace to a line on the floor 3 meters (approximately 10 feet) away, turn, and return to the chair and sit down again. The subject walks through the test once before being timed in order to become familiar with the test. Either a wrist watch with a second hand or a stop-watch can be used to time the performance.

Time to perform "Up and Go" ☐☐.☐ seconds

III. COGNITION ***This section is only completed Pretreatment and at the end of treatment***

ORIENTATION-MEMORY-CONCENTRATION TEST**			
	Patient's Response	**Maximum errors**	**Final Score Weight score**
1. What year is it now? [without looking at a calendar]	☐☐☐☐	1	☐☐ x 4 = ☐☐
2. What month is it now? [without looking at a calendar]	☐☐	1	☐☐ x 3 = ☐☐
Memory Phrase:			

Repeat this phrase after me: 'John Brown, 42 Market Street, Chicago'			
3. About what <u>time</u> is it? [within 1 hour – without looking at your watch]	☐☐:☐☐	1	☐☐ x 3 = ☐☐
4. <u>Count</u> backwards 20 to 1.		2	☐☐ x 2 = ☐☐
5. Say the months in reverse order.		2	☐☐ x 2 = ☐☐
6. Repeat the Memory Phrase.		5	☐☐ x 2 = ☐☐
			TOTAL SCORE: ☐☐

Scoring: For items 1 to 3, the response is either correct (score 0) or incorrect (score 1). For items 4 to 6, add one point for each error (item 4 and 5 maximum error is 2; for item 6, maximum error is 5); total all scores in "Final Score" column. Data from participants found to have gross cognitive impairment as determined by the Orientation-Memory-Concentration Score ≥11 will be excluded from the analysis. Maximum score = 28.

IV. SCORING

Did the patient score ≥11 on the Orientation-Memory-Concentration Test?

☐ No
☐ Yes (**If yes, notify the patient's treating physician.)**

V. NUTRITION

What is the patient's height? (*from patient's chart*) ☐☐☐ cm

What is the patient's current weight? (*from patient's chart*) ☐☐☐ kg

What was the patient's weight approximately 6 months ago? *(from patient's chart or patients self-report)* ☐☐☐ kg

PATIENT REPORTED OUTCOMES

The direct link to the specific PROs (approximately 40 brief questions on symptoms experienced in the last 7 days) to be used for this study is below and is available in many languages (English, traditional Chinese, Czech, Danish, Dutch, French, French Canadian, German, Greek, Hungarian, Italian, Japanese, Korean, Polish, Russian, Spanish). All surveys in all available languages can be printed directly from the NCI website survey link here. Once on the survey link, you can click on the language of interest to get survey for printing. Patients will also be sent an email link for the survey in case they prefer to fill it out this way.

https://healthcaredelivery.cancer.gov/pro-ctcae/build.php?r=H76krM4DOAi

CLINICIAN SURVEY ABOUT ANTICIPATED TOXICITY (BASELINE)

1. What is your best estimate of this patients ECOG PS status? See table below for reference if needed: _____

SCORE	EASTERN COOPERATIVE ONCOLOGY GROUP (ECOG)
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light housework, office work
2	Ambulatory and capable of all selfcare but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited selfcare, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any selfcare. Totally confined to bed or chair
5	Dead

2. As best as you can estimate, what do you think the likelihood is for this patient to develop a grade 3 or higher (severe of life threatening) toxicity event during their chemotherapy course?
   - ☐ Less than or equal to 10%
   - ☐ 10-20%
   - ☐ 21-40%
   - ☐ 41-60%
   - ☐ >60%
   - ☐ I am not sure, can't answer

3. As best as you can estimate, if a grade 3 or higher (severe or life threatening) toxicity event occurs, which do you think is/are most likely to occur in this patient? Please select up to three.

☐ Neutropenia	☐ Poor appetite or weight loss	☐ Pulmonary symptoms
☐ Anemia	☐ Mucositis	☐ Diarrhea
☐ Thrombocytopenia	☐ Neuropathy	☐ Fatigue
☐ Liver dysfunction	☐ Rashes	☐ Pain or arthralgia
☐ Nausea or vomiting	☐ Infection	☐ Other _____

CLINICIAN SURVEY ON UTILITY OF THE GERIATRIC ASSESSMENT INFORMATION (BASELINE)

Approximately one week ago, you received a summary of results from the baseline Geriatric Assessment your patient, ____XXXX, completed on the ADVANCE study. We would like to ask you 4 brief questions about whether this information was helpful to you. Please answer as honestly as possible. Your answers will not be linked to your name and will kept confidential.

1. Did you review the results of the Geriatric Assessment when they were provided to you?
   - ☐ Yes
   - ☐ No
   - ☐ Not sure

   1A. If yes, did you find the layout and way the information was provided easy to read?
   - ☐ Yes
   - ☐ No
   - ☐ Suggestions? _____

2. Did you find the information provided helpful in caring for this patient?
   - ☐ Yes
   - ☐ No
   - ☐ Not sure

3. Did the information result in any changes in your management or referrals you would not have otherwise made, even if something minor?
   - ☐ Yes → please answer 3A below
   - ☐ No
   - ☐ Not sure

   3A. If yes, can you tell what it was? _____

Thank you so much for participating and for your support of the ADVANCE study!