CANCER CENTER PRELIMINARY PLAN

1. Plan of care to be completed by Care Coordinator during multidisciplinary visit.
2. Completed form to be faxed to referring physician, other physician, and Cardiology Specialist indicated.

Referring Physician: ____________________________
Other Physician Name: ____________________________
Other Physician Specialty: ____________________________
Other Physician Fax #: ____________________________
Fax #: ____________________________
Other Physician Phone #: ____________________________
Other Physician: ____________________________
Other Physician Fax #: ____________________________
Other Physician Phone #: ____________________________

Patient’s Name: ____________________________
NCCN guidelines recommended: ☐ Yes ☐ No
Insured: ☐ Yes ☐ No
2nd Opinion: ☐ Yes ☐ No

Date Seen: / / _______
Date of Referral: / / _______
Chief complaint: ____________________________
Primary Diagnosis: ____________________________
Secondary Diagnosis: ____________________________

Cancer Stage Classification:
☐ Clinical staging
☐ Pathologic staging
☐ Working staging

Cancer Stage Grouping:

Cancer Stage Primary Tumor T: _______
Cancer Stage Regional Lymph Node N: _______
Cancer Stage Distant Metastases M: _______

Multi-disciplinary Team:
☐ Acoustic Neuroma
☐ General Oncology
☐ Hepatobiliary/Pancreas
☐ Pain Consultant
☐ Thyroid
☐ Bone Metastases
☐ Genetic Risk Assessment
☐ Lymphoma
☐ Rehabilitation
☐ Young Adult Follow-up
☐ Breast
☐ Genitourinary
☐ Melanoma
☐ Sarcoma
☐ Colorectal
☐ Gynecological
☐ Neuro Oncology
☐ Survivorship
☐ Gastrointestinal
☐ Head/Neck
☐ Ostomy
☐ Thoracic/ Esophageal

Multi-disciplinary Team Members:
Medical Oncologist ____________________________
Radiation Oncologist ____________________________
Surgeon ____________________________
Rehab Medicine Physician ____________________________
Anesthesiologist ____________________________
Neurosurgeon ____________________________
Hematologist ____________________________
Endocrinologist ____________________________
Nuclear Medicine Physician ____________________________
Interventional Radiologist ____________________________

Cancer Note dictated by ____________________________
Other Specialist ____________________________

Multi-disciplinary Lead:
☐ Medical Oncologist
☐ Radiation Oncologist
☐ Surgeon
☐ Hematologist
☐ Rehab Physician
☐ Neuro surgeon
☐ Anesthesiologist

Impression 1:
Plan:
Target Date: / / _______

Impression 2:
Plan:
Target Date: / / _______

Impression 3:
Plan:
Target Date: / / _______

Recommended Treatment: ☐ None ☐ Chemo Therapy ☐ CyberKnife ☐ Radiation Therapy ☐ Surgery ☐ Other ____________________________

Comments: ____________________________

Clinical Trial Candidate: ☐ Yes ☐ No
Comment ____________________________

Reason Not on Clinical Trial:
☐ Patient Refusal ☐ Comorbidity Condition ☐ Other ____________________________

Cancer Programs Participation: Are you currently or have you ever been enrolled:
☐ ELCAP - Early Lung Cancer Action Program ☐ Tissue Procurement ☐ Other ____________________________

Current Tissue Procurement Consent: ☐ Not a candidate ☐ Yes ☐ No ____________________________

Referring physician return date: / / _______
Date Form Completed: / / _______

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