CHRISTIANA CARE

Helen F. Graham Cancer Center

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: _____ **Fax #:** _____ **Phone**

Other Physician Name:	**Other Physician Specialty:**	**Other Physician Fax #:**	**Other Physician**
	Cardiologist		

Patient's Name: _____ **NCCN guidelines recommended** ☐ Yes ☐ No

Date Seen: / / **Insured** ☐ Yes ☐ No

Date of Referral: / / **2nd Opinion** ☐ Yes ☐ No

Chief complaint: _____ **Visit Type** ☐ Initial Evaluation ☐ Follow-up

Primary Diagnosis: _____ **Diagnosis Type** ☐ Preliminary ☐ Definitive

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**	_____	**Care Coordinator**
_____	**Radiation Oncologist**	_____	**Cancer Research**
_____	**Surgeon**	_____	**Dentist**
_____	**Rehab Medicine Physician**	_____	**Genetic Counselor**
_____	**Anesthesiologist**	_____	**Health Psychologist**
_____	**Neurosurgeon**	_____	**Registered Dietitian**
_____	**Hematologist**	_____	**Social Worker**
_____	**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:** / /

Care Coordinator Signature: _____ **Date Form Completed:** / /

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