



**CANCER SERVICES
ST VINCENT'S HOSPITAL
BREAST MULTIDISCIPLINARY TREATMENT PLAN**



Date:

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This patient was discussed at the Breast Cancer Multidisciplinary Team Meeting on / /
Please find a summary of the proposed management plan for this patient.

Procedures Performed:		
<input type="checkbox"/> Biopsy	<input type="checkbox"/> Wide Local Excision (Lumpectomy)	<input type="checkbox"/> Mastectomy
<input type="checkbox"/> Sentinel Node Biopsy	<input type="checkbox"/> Axillary Clearance	<input type="checkbox"/> Breast Reconstruction
Other		
Results:		
Side <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Bilateral		
Pathology	<input type="checkbox"/> In-situ	Type..... Size..... Grade.....
		<input type="checkbox"/> Invasive Type Size Grade.....
Lymph nodes status/.....		Distant metastases <input type="checkbox"/> No <input type="checkbox"/> Yes - Location.....
Receptors: ER + <input type="checkbox"/> - <input type="checkbox"/> PR + <input type="checkbox"/> - <input type="checkbox"/> HER2 + <input type="checkbox"/> - <input type="checkbox"/>		
Psychosocial/Supportive Care Issues:		
.....		
.....		
Referrals <input type="checkbox"/> Not required <input type="checkbox"/> Referred to:		
Treatment Intent:		
<input type="checkbox"/> Curative <input type="checkbox"/> Palliative		Patient aware of intent <input type="checkbox"/> Yes <input type="checkbox"/> No
Recommended Treatment/Institution of Treatment:		
<input type="checkbox"/> Further Surgery		
<input type="checkbox"/> Systemic Therapy (Hormone and Chemotherapy).....		
<input type="checkbox"/> Radiotherapy.....		
Follow-up Arrangements:		
Appointment	Date	Person responsible for making appointment
Other Comments:		
.....		
.....		

Should you have any questions or concerns, please contact me at Tel 03 9288 xxxx/Fax 03 9288 xxxx (office hours) Tuesday/Wednesday/ Thursday.

<name> (Breast Care Nurse) on behalf of the Breast Cancer Multidisciplinary Team

INTERNAL USE ONLY

Attendance:			
Surgeons <input type="checkbox"/> <name 1> <input type="checkbox"/> <name 2> <input type="checkbox"/> <name 3> <input type="checkbox"/> Fellow <input type="checkbox"/>	Medical Oncologists <input type="checkbox"/> <name 1> <input type="checkbox"/> <name 2> <input type="checkbox"/> Fellow <input type="checkbox"/>	Radiation Oncologists <input type="checkbox"/> <name 1> <input type="checkbox"/> <name 2> <input type="checkbox"/>	Pathologist <input type="checkbox"/> <name 1> <input type="checkbox"/>
Radiologist <input type="checkbox"/> <name 1> <input type="checkbox"/>	Breast Care Nurse <input type="checkbox"/> <name 1> <input type="checkbox"/>	Social Worker <input type="checkbox"/> <name 1> <input type="checkbox"/>	Other <input type="checkbox"/> <name 1> <input type="checkbox"/>

Faxed to:		
Doctor/Institution	Fax Number	Date