

<insert logo>

<insert patient details/sticker>

### COLORECTAL MULTIDISCIPLINARY TEAM TREATMENT PLAN

Meeting Date:

Referring Clinician:

GP:

<b>Attendance:</b>			
<input type="checkbox"/> Surgical Oncologist	<input type="checkbox"/> Medical Oncologist	<input type="checkbox"/> Radiation Oncologist	<input type="checkbox"/> Pathologist
<input type="checkbox"/> Radiologist	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Nursing Representative	<input type="checkbox"/> Stomal Therapist
<input type="checkbox"/> Genetic Counselling	<input type="checkbox"/> Social Worker	<input type="checkbox"/> Palliative Care Representative	<input type="checkbox"/> Dietetics
Other (please specify) .....			
<b>Diagnosis:</b>			
Location .....		Tumour Type.....	
Lymph Nodes Involved ...../.....		Distant metastases <input type="checkbox"/> No <input type="checkbox"/> Yes Location.....	
Stage T .... N.... M....		Staging based on <input type="checkbox"/> Pathology <input type="checkbox"/> Imaging <input type="checkbox"/> Other (state).....	
<b>Treatment Intent:</b>			
<input type="checkbox"/> Curative <input type="checkbox"/> Palliative			
<b>Recommended Treatment Plan:</b>			
<input type="checkbox"/> Surgery		Details.....	
<input type="checkbox"/> Chemotherapy		Details.....	
<input type="checkbox"/> Radiotherapy		Details.....	
<input type="checkbox"/> Clinical Trial		Details.....	
<input type="checkbox"/> Watch and Wait		Details.....	
<input type="checkbox"/> Other		Details.....	
<b>Follow-up Arrangements:</b>			
Action		When	Person Responsible
<b>Psychosocial/Supportive Care Issues:</b>			
.....			
.....			
Referral <input type="checkbox"/> Not required <input type="checkbox"/> Referred to: .....			
<b>Other Comments:</b>			

Meeting Recorded By: <name> <position>