



Surname: _____
 Given Name: _____
 Address: _____
 Phone Number: _____
 Date of Birth: _____
 Western Health UR: _____

Oncology Multidisciplinary Team Treatment Plan

Meeting Date: _____
Tumour Stream: **Colorectal**

To be completed by Registrar Diagnosis: <input type="checkbox"/> Initial Diagnosis <input type="checkbox"/> Colon <input type="checkbox"/> Rectal <input type="checkbox"/> Anal	Staging TNM Resectable Metastasis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Potentially	<input type="checkbox"/> Primary <input type="checkbox"/> Recurrence
--	--	---

Issues for MDT Discussion:

<input type="checkbox"/> Neoadjuvant curative Rx	<input type="checkbox"/> Resection of primary	<input type="checkbox"/> Adjuvant curative Rx	<input type="checkbox"/> Curative surgery for metastasis	<input type="checkbox"/> Palliative Rx
--	---	---	--	--

Treatment Plan: Tick all that apply

Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Discussed post-op <input type="checkbox"/> For primary <input type="checkbox"/> For metastasis Which to resect first: <input type="checkbox"/> Primary <input type="checkbox"/> Metastasis	Further Investigations Required <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Tick all that are required:</i> <input type="checkbox"/> CT CAP now / ___ months <input type="checkbox"/> MRI now / ___ months <input type="checkbox"/> PET now / ___ months <input type="checkbox"/> Colonoscopy now / ___ months <input type="checkbox"/> CEA now / ___ months <input type="checkbox"/> Other _____
Radiotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pre-operative short course <input type="checkbox"/> Pre-operative long course <input type="checkbox"/> Post-operative <input type="checkbox"/> Palliative	
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinical Trial <input type="checkbox"/> Palliative <input type="checkbox"/> Neo-adjuvant <input type="checkbox"/> Adjuvant	

Proposed Regimen (use codes below)

FU= 5FU	OX= Oxaliplatin	LE= Leucovorin	CE= Cetuximab
XE= Capecitabine	IR= Irinotecan	BA= Bevacizumab	OT= other

Watch and Wait **Other** _____

Required Referrals Medical	Required Referrals Allied Health
-----------------------------------	---

Follow up arrangements: _____ **Delegated to:** _____

 Registrar completing document

Name: _____ **Signature:** _____ **Date:** _____

Patient Discussion Outcome: (to be completed by treating team)

Patient Informed and Agreed with recommended Treatment Plan

Patient Informed and Agreed with Alternative Treatment Plan (as indicated below)

Patient Informed by: _____ Signature: _____ Date: _____	Treatment Plan communicated to: Name: Fax No: Name: Fax No:
--	--