



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

Oncology Multidisciplinary Team Treatment Plan

Date: _____

Tumour Stream:

To be completed by Registrar
Diagnosis: _____

- Primary
- Recurrence

Primary Treating Unit: _____

General Practitioner _____
GP Fax _____

Recommended Treatment Plan:

- Referrals required:
- Oncology
 - Dietician
 - Occupational Therapy
 - Palliative Care
 - Physiotherapy
 - Psychology Services
 - Radiotherapy
 - Social Work
 - Speech Therapy
 - Stomal Therapist
 - Other:

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 G. P.
Yes
No