

# CINJ/RWJUH Tumor Board Patient List

Tumor Study Group: \_\_\_\_\_

Date: \_\_\_\_\_

Initials & MRN	Attending Physician	Clinical History	Radiologic Studies	Surgical Procedure	Pathology	Stage	Eligible for Clinical Trial?	Treatment Recommended	Adherence to Evidence based Guidelines?
Initials/Name: _____ MR# _____ DOB ____-____-____ Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> New Patient <input type="checkbox"/> Follow-up <input type="checkbox"/>		_____ _____ _____ _____ _____	<input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Mammo <input type="checkbox"/> PET <input type="checkbox"/> USN <input type="checkbox"/> Other	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	T__N__M__  Group _____	Yes <input type="checkbox"/> No <input type="checkbox"/>  Comment:	_____ _____ _____ _____ _____	Yes <input type="checkbox"/>  <input type="checkbox"/> NCCN <input type="checkbox"/> ASCO/ASTRO <input type="checkbox"/> Clin. Trial <input type="checkbox"/> Other  No <input type="checkbox"/>
Initials/Name: _____ MR# _____ DOB ____-____-____ Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> New Patient <input type="checkbox"/> Follow-up <input type="checkbox"/>		_____ _____ _____ _____ _____	<input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Mammo <input type="checkbox"/> PET <input type="checkbox"/> USN <input type="checkbox"/> Other	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	T__N__M__  Group _____	Yes <input type="checkbox"/> No <input type="checkbox"/>  Comment:	_____ _____ _____ _____ _____	Yes <input type="checkbox"/>  <input type="checkbox"/> NCCN <input type="checkbox"/> ASCO/ASTRO <input type="checkbox"/> Clin. Trial <input type="checkbox"/> Other  No <input type="checkbox"/>
Initials/Name: _____ MR# _____ DOB ____-____-____ Prospective <input type="checkbox"/> Retrospective <input type="checkbox"/> New Patient <input type="checkbox"/> Follow-up <input type="checkbox"/>		_____ _____ _____ _____ _____	<input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> Mammo <input type="checkbox"/> PET <input type="checkbox"/> USN <input type="checkbox"/> Other	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	T__N__M__  Group _____	Yes <input type="checkbox"/> No <input type="checkbox"/>  Comment:	_____ _____ _____ _____ _____	Yes <input type="checkbox"/>  <input type="checkbox"/> NCCN <input type="checkbox"/> ASCO/ASTRO <input type="checkbox"/> Clin. Trial <input type="checkbox"/> Other  No <input type="checkbox"/>
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