REQUEST FOR TUMOR BOARD APPRAISAL AND RECOMMENDATION

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 - Use Blanket PAS - DD Form 2005)

DATE

LAST NAME - FIRST NAME - MIDDLE INITIAL	SEX	RACE	MEDICAL TREATMENT FACILITY

PATIENT'S ADDRESS	DATE OF BIRTH	SSAN

I. CLINICAL SUMMARY *(To be prepared by attending physician or dentist)*

1. DIAGNOSIS

2. BRIEF HISTORY *(Include initial symtoms; date of symptoms; date seen; how, where and when diagnosis was established)*

3. TREATMENT AND THERAPY PERFORMED

4. OTHER *(Additional therapy proposed; follow-up schedule, etc.)*

TYPED NAME OF ATTENDING PHYSICIAN OR DENTIST	SIGNATURE

II. TUMOR BOARD EVALUATION

5. BOARD RECOMMENDATIONS FOR:

A. TYPED NAME OF ATTENDING PHYSICIAN OR DENTIST:

B. DESIRED FOLLOW-UP SCHEDULE:

C. REQUIREMENT FOR REPEATED PRESENTATION AT SPECIFIED INTERVAL *(If different from attending physician or dentist, AFR 160-64)*

D. VARIANCES *(If any, from majority of tumor board member's recommendations):*

6. REMARKS

7. BOARD MEMBERS PRESENT

TYPED NAME OF TUMOR BOARD RECORDER	SIGNATURE