



**1 : Patient Details**

Surname:  Firstname:  Initials:  ID Number:  First Diagnosed:   
 Gender:  Telephone:  CellPhone:  Dependant Code:  Birth:   
 Postal Address:  Fax:  Email:

**2 : Medical Aid Details**

Principal Member:  Membership Number:  Medical Aid:  Benefit Option:

**3 : Practitioner Detail (Practice)**

Name:  Practice Number:  HPCSA Number:   
 Contact Person:  Telephone Number:  Fax Number:   
 Email Address:  Group Practice:

- Emergency       Urgent

**4 : Patient History**

**Diagnosis and Criteria for PMB Condition**

ICD Code:  Primary Site:   
 Histology:  First Diagnosis Date:   
  
 PMB Code:  Condition:

- Metastatic Spread To Adjacent Organ       Irreversible/ Irreparable damage to organ of origin or other vital organ  
 Evidence of Distant, Metastatic Spread       Well demonstrated 5 year survival rate of greater than 10%



**Second Diagnosis and Criteria for PMB Condition**

ICD Code:  Primary Site:

Histology:  Second Diagnosis Date:

PMB Code:  Condition:

- |   |   |
|---|---|
| <input type="checkbox"/> Metastatic Spread To Adjacent Organ    | <input type="checkbox"/> Irreversible/ Irreparable damage to organ of origin or other vital organ |
| <input type="checkbox"/> Evidence of Distant, Metastatic Spread | <input type="checkbox"/> Demonstrated 5 year survival rate for this cancer is greater than 5%     |

**5 : Other Clinical Information**

Grade:

ECOG Scale:   AJCC:

Disease Stage

T:  N:  M:  Stage Other:

Metastases:  Bone Date:   Brain Date:   Liver Date:   Lung Date:

Other:  Date:

Receptors:

Co-Morbid:

**Treatment History**

Date	Descr	Drugs	Outcome	Comments
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>



**6 : Treatment Intent and Review**

Plan Effective Date:

Treatment Intent:

SAOC Level:

Clinical Trial :

Hormone Manipulation     Radiotherapy

Chemotherapy:

Other:

Hospital Practice No:

Hospital Name:

Hospital Motivation:

Additional Comments:

Treatment Review:

Practitioner Signature: \_\_\_\_\_

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



# South African Oncology Consortium : Oncology Application Form

File Number :

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SAOC Reference :

## 7 : Radiotherapy Treatment - (RAD)

Professional Practice No.:	<input type="text"/>	Name:	<input type="text"/>	Professional Fees:	<input type="text"/>
Technical Practice No.:	<input type="text"/>	Name:	<input type="text"/>	Technical Fees:	<input type="text"/>
Start Date.:	<input type="text"/>	Area of Interest:	<input type="text"/>	Supporting Items :	<input type="text"/>
Duration in Weeks:	<input type="text"/>	Dose:	<input type="text"/>	<b>Total Radiotherapy :</b>	<input type="text"/>
Prostate Volume:	<input type="text"/>	Gleason Grade:	<input type="text"/>	PSA:	<input type="text"/>
		IPSS:	<input type="text"/>	Prostate Stage:	<input type="text"/>
				Hospital :	<input type="text"/>

Radiotherapy Comments:

### Radiotherapy Planning Code

Product Name	Code	Commencement	Week(s)	UnitPrice	Professional	Technical	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Radiotherapy Planning Code Sub Total :**

### Radiation Code

Product Name	Code	Commencement	Week(s)	UnitPrice	Professional	Technical	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Radiation Code Sub Total :**



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Isotope

Product Name	Code	Commencement	Week(s)	UnitPrice	Professional	Technical	Total

Isotope Sub Total :

Brachy Code

Product Name	Code	Commencement	Week(s)	UnitPrice	Professional	Technical	Total

Brachy Code Sub Total :

Supporting Items and Materials

Product Name	Code	Commencement	Week(s)	UnitPrice	Total

Supporting Items and Materials Sub Total :



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## 8 : Chemotherapy Treatment - (CHEM)

Professional Practice No.:

Name:

Chemo Prov Practice No.:

Name:

Facility Practice No.:

Name:

Starting Date.:

Height:  Weight:  Body Surface:

Chemotherapy Comments:

### Chemotherapy : Part 1

StartDate

Cycles

CycleCost

Total Cost

Port Insertion  Hospital:

### Chemotherapy Service Fees

Product Name	Code	Cycle Length	Dosage and Frequency	X-Code	UnitPrice	QTY	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>

Chemotherapy Service Fees Sub Total :



**Chemotherapy Drugs**

Product Name	Code	Cycle Length	Dosage and Frequency	X-Code	UnitPrice	QTY	Total

Chemotherapy Drugs Sub Total :

**Supporting Drugs, Materials and Fluids**

Product Name	Code	Cycle Length	Dosage and Frequency	X-Code	UnitPrice	QTY	Total

Supporting Drugs, Materials and Fluids Sub Total :



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## Chemotherapy : Part 2

StartDate  Cycles  CycleCost  Total Cost  Port Insertion  Hospital:

### Chemotherapy Service Fees

Product Name	Code	Cycle Length	Dosage and Frequency	X-Code	UnitPrice	QTY	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Chemotherapy Service Fees Sub Total :

### Chemotherapy Drugs

Product Name	Code	Cycle Length	Dosage and Frequency	X-Code	UnitPrice	QTY	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Chemotherapy Drugs Sub Total :

### Supporting Drugs, Materials and Fluids

Product Name	Code	Cycle Length	Dosage and Frequency	X-Code	UnitPrice	QTY	Total
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Supporting Drugs, Materials and Fluids Sub Total :