Cancer Care Kenya

Surname Mr/Mrs/Ms First name DOB Postal address Age ZIP code ID No Physical Address Occupation Next of Kin Tele: Tele: Referring clinician Telephone number E mail ID Address Date of referral Brief Medical history ECOG Performance status 0-1-2-3-4 (please leave blank if not familiar) Signs and symptoms Provisional diagnosis	Electronic patient referral form			
Postal address ZIP code IID No Physical Address Occupation Next of Kin Tele: Referring clinician Telephone number E mail ID Address Date of referral Brief Medical history ECOG Performance status 0-1-2-3-4 (please leave blank if not familiar) Signs and symptoms		Mr/Mrs/Ms		
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Signs and symptoms	Brief Medical history			
Signs and symptoms				
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Signs and symptoms				
Signs and symptoms				
	ECOG Performance status 0-1-2-3-4 (please leave blank if not familiar)			
	Signs and symptoms			
Provisional diagnosis	Signs and symptoms			
Provisional diagnosis				
Provisional diagnosis				
Provisional diagnosis				

Physical examination	
Investigations (please fill up the available	e results)
CBC	
RFT	
LFT	
Others	
Urine	
X-ray	
USG	
Mammography	
ECG	
CT	
MRI	
Tumor markers	
Others if any	
Histology	
Diagnosis	TNM(please leave blank if not familiar)
Co morbidities ,if any:	
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Current medications	
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Social and family history			
G : 1 1 :C			
Special needs, if necessary			
Clinical diagram (Optional)			
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Treatment plan (please leave blank if not familiar)			
		1	
	a		
Intent of treatment	Curative	Palliative	
DI.			
Place:			
Date:			
Please mail to: <u>info@cancercarekenya.com</u> .			