



## Colorado Choice Health Plans/SLVHMO HEMATOLOGY - ONCOLOGY TREATMENT PLAN

700 Main, #100, Alamosa, CO 81101 Phone: (719) 589-3696 Fax: (719) 589-4995

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Please complete the following information for the above-named member and fax to the number above. This information is necessary to assure that all required preauthorizations are in place and assist in care coordination. Should any changes in the plan be required, please notify us at the above number.

**CHEMOTHERAPY PLANNED?**  No  Yes ⇨ Complete the following

Medical Oncologist: \_\_\_\_\_ Facility/Location: \_\_\_\_\_

Chemotherapeutic agents with dosages and routes:

Frequency of administration: \_\_\_\_\_

Duration of treatment: \_\_\_\_\_ Number of cycles: \_\_\_\_\_

**RADIATION PLANNED?**  No  Yes ⇨ Complete the following

Radiation Oncologist: \_\_\_\_\_ Facility/Location: \_\_\_\_\_

Start Date: \_\_\_\_\_ Planned Dose: \_\_\_\_\_

Number of Treatments: \_\_\_\_\_ Duration of Treatments: \_\_\_\_\_

**PROPOSED SURGERY?**  No  Yes ⇨ Complete the following

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

Surgeon: \_\_\_\_\_ Facility/Location: \_\_\_\_\_

Timing in conjunction with above treatment modalities: \_\_\_\_\_

**IMAGING REQUIRED?**  No  Yes ⇨ Complete the following

CT scans  PET scans  Ultrasound  Other \_\_\_\_\_ Expected Date(s): \_\_\_\_\_

**OTHER PERTINENT INFORMATION:**