



CANCER CENTRE
 OF SOUTHEASTERN ONTARIO
 AT KINGSTON GENERAL HOSPITAL
 a cancer care ontario partner

SYSTEMIC THERAPY BOOKING FORM

Name _____

KRCC# _____

CR# _____

ADDRESSOGRAPH

Date: _____
 (YY/MM/DD)

Regimen: _____

Start Date: _____
 (YY/MM/DD)

Diagnosis: _____

Physician: _____ Nurse: _____

Clinical Trial: No Yes Study ID _____

VAD: No Yes - PICC Port Hickman TBA

Radiotherapy: No Yes Concurrent Sequential

Current or Previous Cycles of Chemotherapy: No Yes – Where: _____

Latex Allergy: No Yes

Other Precautions: _____

UNIT CLERK USE ONLY:

Systemic Therapy booked : _____
 (YY/MM/DD) (Time) (Initial)

Patient/family notified : _____
 (YY/MM/DD) (Time) (Initial)

Scheduling Issues: No Yes, Describe: _____

(Initial)

(Signature)

(Initial)

(Signature)

