MEDICAL ELIGIBILITY

APPLICATION FORM (TREATMENT)

(TO BE COMPLETED BY VETERINARY SURGEON AT REFERRAL TREATMENT CENTRE)

Please do not submit an application if the expected median survival time with the proposed treatment is <12 months. In this case, please email admin@zeusandpj.org to let us know. We do not share information submitted via this form with owners. We only fund cancer treatment, and do not fund rescue protocols, palliative care or euthanasia.

List of cancer types not covered

- Acute leukaemia (lymphoid, myeloid, erythroid)
- Gastric carcinoma
- Certain forms of histiocytic sarcoma
    - Disseminated
    - Haemophagocytic
- Pancreatic carcinoma
- Prostatic carcinoma
- Stage IV oral melanoma
- Certain forms of haemangiosarcoma
    - Stage II-III splenic haemangiosarcoma
    - Cardiac haemangiosarcoma
    - Subcutaneous haemangiosarcoma
- Certain forms of osteosarcoma
    - Stage III appendicular osteosarcoma (e.g. distant metastasis at time of diagnosis)
    - Extraskeletal osteosarcoma
    - Vertebral osteosarcoma
- Certain forms of lymphoma
    - Mediastinal lymphoma
    - High-grade/biologically aggressive cutaneous lymphoma
    - Gastrointestinal lymphoma
    - Large granular lymphocyte (LGL) lymphoma
    - Any relapsed lymphoma

Note: we will not fund treatment for mammary tumours if neutering at the time of treatment is advised by the responsible veterinary surgeon and this is not followed.

Once completed, please return to: ***admin@zeusandpj.org***

Section 1: Patient Information

1.1 - Dog's name *(Required)*

1.2 - Owner's name *(Required)*

1.3 - Signalment

Age *(Required)*

ENTER AGE (YEARS/MONTHS)

Weight *(Required)*

ENTER WEIGHT (KG)

Breed *(Required)*

Sex *(Required)*

- ❑ ME
- ❑ FE
- ❑ MN
- ❑ FN

1.4 - Is the dog in good condition? *(Required)*

- ❑ Yes
- ❑ No

Section 2: Treatment Centre Information

2.1 - Treatment center *(Required)*

ENTER REFERRAL HOSPITAL/CLINIC NAME

2.2 - Contact detail: TREATMENT CENTRE ADDRESS *(Required)*

Street Address

House number

City

Country *(Required)*

Postcode

E-mail address *(Required)*

Telephone number *(Required)*

2.3 - Qualification

Does the veterinary team managing this case include board-certified medical and/or radiation oncologists, surgeons, or internal medics? *(Required)*

- ❑ Yes
- ❑ No

If no, please provide details of relevant qualifications/experience of the veterinary surgeon(s) responsible for this case *(Required)*

2.4 - Responsible veterinary surgeon

If there will be one veterinary surgeon primarily managing this case, please identify here *(Required)*

2.5 - Primary care practice

Name and address of dog's primary care practice (if known)

Section 3: Clinical Information

3.1 - Cancer *(all sections MUST be completed)*

Diagnosis: *(Required)*

ENTER THE CANCER TYPE / SUBTYPE / IMMUNOPHENOTYPE

Date of diagnosis: *(Required)*

DD/MM/YYYY

Clinical signs: *(Required)*

BRIEFLY SUMMARIZE ANY CLINICAL SIGNS RELATED TO THE TUMOUR

Tumour location: *(Required)*

PLEASE ENTER THE TUMOUR LOCATION

Stage: *(Required)*

ENTER STAGE (IF NOT KNOW PLEASE ENTER 'UNKNOWN')

Metastasis: *(Required)*

- ❑ Yes
- ❑ No

IF METASTASIS, PLEASE DESCRIBE THE LOCATION AND EXTENT

Grade: *(Required)*

ENTER THE TUMOUR GRADE IF APPLICABLE (IF NOT KNOWN PLEASE ENTER 'UNKNOWN')

Prognostic factors: *(Required)*

PLEASE DESCRIBE ANY RELEVANT POSITIVE OR NEGATIVE PROGNOSTIC FACTORS FOR THIS SPECIFIC TUMOUR TYPE

Confirm this is a first occurrence of this cancer (e.g. not recurrent or relapsed): *(Required)*

- ❑ Yes
- ❑ No

3.2 - Treatment *(all sections MUST be completed)*

Prior treatment: *(Required)*

PLEASE DETAIL ANY CANCER-SPECIFIC TREATMENT UNDERTAKEN PRIOR TO THIS APPLICATION

Proposed treatment plan: *(Required)*

PLEASE SUMMARIZE THE SPECIFIC TREATMENT PLAN FOR THIS CASE, FOR WHICH FUNDING IS BEING REQUESTED (E.G. FORELIMB AMPUTATION AND ADJUVANT CARBOPLATIN CHEMOTHERAPY FOR AN APPENDICULAR OSTEOSARCOMA, OR 19- WEEK CHOP PROTOCOL FOR MULTICENTRIC LYMPHOMA)

Ideal timeframe for treatment: *(Required)*

PLEASE OUTLINE A TIMEFRAME WITHIN WHICH TREATMENT SHOULD IDEALLY START

Expected median survival time with proposed treatment: *(Required)*

WITH PROPOSED TREATMENT - PLEASE PROVIDE YOUR BEST ESTIMATE OF MEDIAN SURVIVAL TIME FOR THIS CASE WITH THE TREATMENT PROPOSED

Expected median survival time without any treatment: *(Required)*

WITHOUT ANY TREATMENT - PLEASE PROVIDE YOUR BEST ESTIMATE OF MEDIAN SURVIVAL TIME FOR THIS CASE IF NO TREATMENT WERE PURSUED

Common complications associated with treatment: *(Required)*

PLEASE BRIEFLY OUTLINE ANY COMMON POSSIBLE COMPLICATIONS/ADVERSE EFFECTS RELATED TO THE PROPOSED TREATMENT

3.3 - Costs/estimate (all sections MUST be completed)

Estimated cost of proposed treatment, as outlined in section 3.2: *(Required)*

PLEASE ENTER TREATMENT ESTIMATE (IN £)

Estimated total cost of managing potential complications, as outlined in section 3.2: *(Required)*

PLEASE ENTER TREATMENT ESTIMATE FOR ANY COMMON COMPLICATIONS (IN £)

As far as you are aware, is this dog receiving funding for treatment costs from any other sources? *(Required)*

- ❑ Yes
- ❑ No

IF YES, PLEASE OUTLINE

3.4 - Comorbidities

Does the dog have any significant comorbidities that are likely to have a poorer prognosis than the cancer? *(Required)*

- ❑ Yes
- ❑ No

IF YES, PLEASE DESCRIBE - PLEASE OUTLINE ANY SIGNIFICANT COMORBIDITIES AND TREATMENT/ASSOCIATED PROGNOSIS

3.5 - Other

PLEASE PROVIDE ANY OTHER RELEVANT INFORMATION/COMMENTS THAT WOULD BE USEFUL FOR THIS APPLICATION

Section 4: Supporting documents

Please tick to confirm the following files have been attached and included in the application (these MUST be included where available – failure to provide this information may delay the funding decision): *(Required)*

- ❑ Medical history
- ❑ Recent referral discharge letter
- ❑ Imaging report(s)
- ❑ Cytology report(s)
- ❑ Histopathology report(s)

NOTE: LEAVE BOXES BLANK IF INFORMATION UNAVAILABLE

Name of veterinary surgeon completing application:

ENTER YOUR FULL NAME

DATE: DD/MM/YYYY