

**Subject Screening/MDT Log at Feasibility Centres [FOR RECORDING INDIVIDUALS with MIBC screened for trial eligibility]**

Study Title:	MIAMI MDT Audit - Assess All Cases based on Feasibility Trial Eligibility Criteria (includes MRI diagnosis) <b>Please also add all cases you would otherwise consider for neoadjuvant chemotherapy</b>		
Investigator:		Site name/no.:	
R&D Number:	NA	REC no.:	NA

Initials	DOB (dd/mm/yy)	Mamo/US diagnosis (dd/mm/yy) ...../...../.....  Size largest focus (mm):..... Eligible by disease extent: Yes No (Please Circle)  No. disease sites: ..... MRI diagnosis (dd/mm/yy) Eligible by disease extent: Yes No (Please Circle) Diagnosed only by MRI: Yes No (Please Circle)	Define MF or MC (footnote)	Feasibility TM (Y/N)	Date Consult Oncoplastic Surgeon	Is the subject eligible?	If not eligible (list for e.g.: EIC DCIS, Technical, Morbidity, Neo-adjuvant)	Date of final MDT decision (dd/mm/yy)  Record type of surgery performed: (Mast/TM)	If yes: Boost RT to 1-2 sites is permissible:  0 1 2 (Please Circle)
									0 – None 1 – One site 2 – Two sites
		Mamo/US diagnosis (dd/mm/yy) ...../...../.....  Size largest focus (mm):..... Eligible by disease extent: Yes No (Please Circle)  No. disease sites: ..... MRI diagnosis (dd/mm/yy) Eligible by disease extent: Yes No (Please Circle) Diagnosed only by MRI: Yes No (Please Circle)				<input type="checkbox"/> Yes  <input type="checkbox"/> No			
		Mamo/US diagnosis (dd/mm/yy) ...../...../.....  Size largest focus (mm):..... Eligible by disease extent: Yes No (Please Circle)  No. disease sites: ..... MRI diagnosis (dd/mm/yy) Eligible by disease extent: Yes No (Please Circle) Diagnosed only by MRI: Yes No (Please Circle)				<input type="checkbox"/> Yes  <input type="checkbox"/> No			
		Mamo/US diagnosis (dd/mm/yy) ...../...../.....  Size largest focus (mm):..... Eligible by disease extent: Yes No (Please Circle)  No. disease sites: ..... MRI diagnosis (dd/mm/yy) Eligible by disease extent: Yes No (Please Circle) Diagnosed only by MRI: Yes No (Please Circle)				<input type="checkbox"/> Yes  <input type="checkbox"/> No			
		Mamo/US diagnosis (dd/mm/yy) ...../...../.....  Size largest focus (mm):..... Eligible by disease extent: Yes No (Please Circle)  No. disease sites: ..... MRI diagnosis (dd/mm/yy) Eligible by disease extent: Yes No (Please Circle) Diagnosed only by MRI: Yes No (Please Circle)				<input type="checkbox"/> Yes  <input type="checkbox"/> No			

**Ensure you are using the current version of this document.** This document is reviewed at least every two years