Oncology Medical Merit
SCREENING TOOL

BASIC CASE INFORMATION

- ☐ Patient age at time of events:_____
- ☐ Type of cancer (if officially diagnosed based on pathology): _____
- ☐ Date of confirmed diagnosis: _____
- ☐ Stage at time of diagnosis (if known): _____
- ☐ Current status (alive, deceased, ongoing treatment):_____

TIMELINE OF EVENTS

- ☐ Date of 1st symptom or abnormal finding:_____
- ☐ Date of initial provider visit:_____ Name & specialty of provider: _____
- ☐ Key symptoms documented:_____
- ☐ Dates of subsequent visits:_____
- ☐ Date diagnostic workup Initiated:_____
- ☐ Date of official diagnosis (based on pathology):_____

RED FLAGS PRESENT IN THE RECORD

(check all that apply)

- ☐ Persistent or worsening symptoms
- ☐ Unintentional weight loss
- ☐ Abnormal labs (anemia, elevated markers, etc)
- ☐ Suspicious findings on imaging
- ☐ Palpable mass or lesion
- ☐ Repeated visits for same complaint

Abnormal test results & follow up

- [ ] Were abnormal results identified? Yes No
- [ ] If yes, were they acknowledged in the chart? Yes No
- [ ] Was appropriate follow up ordered? Yes No
- [ ] Was the patient notified? Yes No

Diagnostic workup

- [ ] Imaging performed? Yes No If yes, what tests?_____
- [ ] Time from symptom reported to time of imaging:_____
- [ ] Biopsy performed? Yes No If yes, how soon after imaging? _____
- [ ] Specialist referral made ? Yes No If yes, what specialty?_____
- [ ] Time from specialist referral to specialty visit:_____
- [ ] Any unexplained delays at any step in the diagnostic pathway?_____

REFERRAL & ESCALATION OF CARE

- ☐ Referral placed when indicated?: Yes No
- ☐ Referral marked as urgent? Yes No
- ☐ Follow up on referral completion documented? Yes No

Potential red flag: "Watchful waiting" documented without a clear follow up plan or timeframe.

COMMUNICATION & COORDINATION OF CARE

- ☐ Documentation of discussions with the patient about diagnosis and plan of care going forward? Yes No
- ☐ Evidence that results were communicated to patient? Yes No
- ☐ Clear ownership of follow up? Yes No

High risk pattern: Multiple providers involved with no clear responsibility assigned

DOCUMENTATION OF CLINICAL DECISION MAKING

- ☐ Differential diagnoses documented? Yes No
- ☐ Clinical reasoning explained? Yes No
- ☐ Rationale for not pursuing workup documented? Yes No

Absence of documented reasoning weakens defense – even if care may have been appropriate

HARM & DAMAGES ASSESSMENT

- ☐ Disease progression during delay? Yes No
- ☐ Was there a change in stage? Yes No
- ☐ Was there a change in treatment intensity? Yes No
- ☐ If the answer was 'Yes' to any of the above was there a reason documented? Yes No
- ☐ Impact on survival/prognosis? Yes No

Case strength snapshot

Assign 1pt for each "Yes"

- [ ] Documented delay in diagnosis
- [ ] Abnormal findings not followed
- [ ] Multiple missed opportunities
- [ ] Poor or absent documentation
- [ ] Lack of care coordination
- [ ] Demonstratable harm from delay

0-2: low medical merit **3-4:** Mod, needs deeper review **5-6** High value case/strong potential

Cases involving delayed cancer diagnosis require more than record review—they require clinical context. As an oncology-trained nurse practitioner and legal nurse consultant, I help identify where care deviated from expected clinical pathways—and where that deviation matters legally.