

Cancer Treatment Plan and Summary

[Insert Practice Name/Info Here]

The Treatment Plan and Summary is a brief record of major aspects of cancer treatment. This is not a complete patient history or comprehensive record of intended therapies.

Patient name:		Patient ID:
Medical oncology provider name:		PCP:
Patient DOB: (___ / ___ / ___)	Age:	Patient phone:
Support contact name:		
Support contact relationship:	Support contact phone:	

BACKGROUND INFORMATION

Symptoms/signs:
Family history/predisposing conditions:
Major co-morbid conditions:
Tobacco use: <input type="checkbox"/> No <input type="checkbox"/> Yes, past <input type="checkbox"/> Yes, current (If current, cessation counseling provided?: <input type="checkbox"/> Yes <input type="checkbox"/> No)
Cancer type/location:
Diagnosis date: (___ / ___ / ___)
Is this a new cancer diagnosis or recurrence?: <input type="checkbox"/> New <input type="checkbox"/> Recurrence (date: ___ / ___ / ___)
Surgery: <input type="checkbox"/> None <input type="checkbox"/> Diagnosis only <input type="checkbox"/> Palliative resection <input type="checkbox"/> Curative resection
Surgical procedure/location/findings:
Tumor type/histology/grade:

STAGING

Study	Date	Findings

T stage: <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4 <input type="checkbox"/> Not applicable	N stage: <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 <input type="checkbox"/> Not applicable
M stage: <input type="checkbox"/> M0 <input type="checkbox"/> M1 <input type="checkbox"/> Not applicable	Tumor markers:
Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Recurrence	Alternative staging system: _____
Location(s) of metastasis or recurrence (if applicable):	

TREATMENT PLAN

TREATMENT SUMMARY

White sections to be completed prior to chemotherapy administration, shaded sections following chemotherapy

Height: _____ in/cm	Pre-treatment weight: _____ lb/kg	Post-treatment weight: _____ lb/kg			
Pre-treatment BSA: _____	Treatment on clinical trial: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of chemotherapy regimen:					
Chemotherapy start date: (___ / ___ / ___)		Chemotherapy end date: (___ / ___ / ___)			
Chemotherapy intent: <input type="checkbox"/> Curative, adjuvant or neoadjuvant <input type="checkbox"/> Disease or symptom control					
ECOG performance status at start of treatment: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		ECOG performance status at end of treatment: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4			
Chemotherapy Drug Name	Route	Dose mg/m ²	Schedule	Dose reduction	# cycles administered
				<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	
				<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	
				<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	
				<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	
				<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	
				<input type="checkbox"/> Yes _____% <input type="checkbox"/> No	

Major side effects of this regimen: <input type="checkbox"/> Hair loss <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Neuropathy <input type="checkbox"/> Low blood count <input type="checkbox"/> Fatigue
<input type="checkbox"/> Menopause symptoms <input type="checkbox"/> Cardiac <input type="checkbox"/> Other _____

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Important caution: this is a summary document whose purpose is to review the highlights of the cancer treatment for this patient. This does not replace information available in the medical record, a complete medical history provided by the patient, examination and diagnostic information, or educational materials that describe strategies for coping with cancer and cancer therapies in detail. Both medical science and an individual's health care needs change, and therefore this document is current only as of the date of preparation. This summary document does not prescribe or recommend any particular medical treatment or care for cancer or any other disease and does not substitute for the independent medical judgment of the treating professional.

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FOLLOW-UP AND SURVIVORSHIP CARE

Follow up care	When/How Often?	Coordinating Provider
Medical oncology visits		
Lab tests		
Imaging		

Potential late effects of treatment(s):

Call your doctor if you have any of these signs and symptoms:

- Needs or concerns:**
- Prevention and wellness: _____
 - Genetic risk: _____
 - Emotional or mental health: _____
 - Personal relationships: _____
 - Fertility: _____
 - Financial advice or assistance: _____
 - Other: _____

- Referrals provided:**
- Dietician
 - Smoking cessation counselor
 - Physical therapist or exercise specialist
 - Genetic counselor
 - Psychiatrist
 - Psychologist
 - Social worker
 - Fertility specialist or endocrinologist
 - Other: _____

Comments