



# Cancer Treatment Summary - Follow-up Care Plan

Date:

Completed by:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Cancer Diagnosis: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_

Date Completed Therapy: \_\_\_\_\_ Relapse: \_\_\_\_\_

## Cancer Treatment

### Surgery

Surgeon: \_\_\_\_\_ Procedure: \_\_\_\_\_

Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Pathology: \_\_\_\_\_

Location: \_\_\_\_\_

### Radiation Therapy

Radiation Oncologist: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Date Start: \_\_\_\_\_ Date Stop: \_\_\_\_\_ Field: \_\_\_\_\_ Dose (cGy): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Potential Late Effects of Treatment:

\_\_\_\_\_

Monitor With:

\_\_\_\_\_

### Chemotherapy/Medical Therapy

Medical Oncologist: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Cumulative Dose (units or mg/m2): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Potential Late Effects of Treatment:

\_\_\_\_\_

Monitor With:

\_\_\_\_\_

### Follow-up Plan

Visit Schedule:

Tests/Frequency:

\_\_\_\_\_

Imaging/Frequency:

\_\_\_\_\_

Other:

**Patient Concerns** **Referrals**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Depression/anxiety:                     | <input type="checkbox"/> Psychiatry               | <input type="checkbox"/> Physical therapy/rehab   |
| <input type="checkbox"/> Fertility:                              | <input type="checkbox"/> Fertility/endocrinology  | <input type="checkbox"/> Counseling regarding employment, insurance, finances                                 |
| <input type="checkbox"/> Marital/partner/family relationships:   | <input type="checkbox"/> Genetic counseling       | <input type="checkbox"/> Complimentary therapies/practices: acupuncture, meditation, reiki, yoga, tai chi...) |
| <input type="checkbox"/> Sexuality:                              | <input type="checkbox"/> Smoking cessation        |   |
| <input type="checkbox"/> Genetic Risk:                           | <input type="checkbox"/> Psychology/social work   |   |
| <input type="checkbox"/> Wellness (diet, exercise...):           | <input type="checkbox"/> Dietician/weight control |   |
| <input type="checkbox"/> Employment, health insurance, finances: | <input type="checkbox"/> Exercise program         |   |
| <input type="checkbox"/> Other:                                  | <input type="checkbox"/> Other                    |   |