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: _ No _ Yes, past _ Yes, current **(If current, cessation counseling provided?**: _ Yes _ No**)**

Cancer type/location: | **Diagnosis date:** (___/___/____)

Is this a new cancer diagnosis or recurrence?: _ New _ Recurrence (date: ___/___/____)

Surgery: _ None _ Diagnosis only _ Palliative resection _ Curative resection

Surgical procedure/location/findings:

Tumor type/histology/grade:

STAGING

Study	Date	Findings

T stage: _ T1 _ T2 _ T3 _ T4 _ Not applicable | **N stage:** _ N0 _ N1 _ N2 _N3 _ Not applicable

M stage: _ M0 _ M1 _ Not applicable | **Tumor markers:**

Stage: _ I__ _ II__ _ III__ _ IV__ _ 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:** _ Yes _ No

Name of chemotherapy regimen:

Chemotherapy start date: (___/___/____) | **Chemotherapy end date:** (___/___/____)

Chemotherapy intent: _ Curative, adjuvant or neoadjuvant _ Disease or symptom control

ECOG performance status at start of treatment: _ 0 _ 1 _ 2 _ 3 _ 4 | **ECOG performance status at end of treatment:** _ 0 _ 1 _ 2 _ 3 _ 4

Chemotherapy Drug Name	Route	Dose mg/m^2	Schedule	Dose reduction	# cycles administered
				_ Yes ______% _ No	
				_ Yes ______% _ No	
				_ Yes ______% _ No	
				_ Yes ______% _ No	
				_ Yes ______% _ No	
				_ Yes ______% _ No	

Major side effects of this regimen: _ Hair loss _ Nausea/Vomiting _ Neuropathy _ Low blood count _ Fatigue _ Menopause symptoms _ Cardiac _ Other __________________________

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TREATMENT PLAN (CONTINUED)			TREATMENT SUMMARY (CONTINUED)
Non-chemotheraputic Agents	**Route**	**Purpose/Goal**	**Comments**

Reason for stopping treatment: _ Completion _ Toxicity _ Progression _ Other:________________

Response to treatment: _ Complete _ Partial _ No response _ Progression _ Not measurable

Treatment-related hospitalization required: _ Yes _ No

Serious toxicities during treatment (list all):

Ongoing toxicity at completion of treatment:
_ Yes (enter type(s) and grade(s) ____)
_ No

ADDITIONAL THERAPIES PLANNED		
Drug name	**Comments**	**Date started (or to start)**
		(___/___/___)
		(___/___/___)
		(___/___/___)

Radiation therapy: _ Not planned
_ Planned
_ Administered Region treated: __________________ Radiation dose: ___________
Date initiated: (___/___/___) Date completed: (___/___/___)

ONCOLOGY TEAM MEMBER CONTACTS	SURVIVORSHIP CARE PROVIDER CONTACTS
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:

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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

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