

# 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.*

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

## BACKGROUND INFORMATION

<b>Symptoms/signs:</b>
<b>Family history/predisposing conditions:</b>
<b>Major co-morbid conditions:</b>
<b>Tobacco use:</b> <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)
<b>Cancer type/location:</b>
<b>Diagnosis date:</b> ( ___ / ___ / ___ )
<b>Is this a new cancer diagnosis or recurrence?:</b> <input type="checkbox"/> New <input type="checkbox"/> Recurrence (date: ___ / ___ / ___ )
<b>Surgery:</b> <input type="checkbox"/> None <input type="checkbox"/> Diagnosis only <input type="checkbox"/> Palliative resection <input type="checkbox"/> Curative resection
<b>Surgical procedure/location/findings:</b>
<b>Tumor type/histology/grade:</b>

## STAGING

Study	Date	Findings

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

## TREATMENT PLAN

## TREATMENT SUMMARY

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

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

<b>Major side effects of this regimen:</b> <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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TREATMENT PLAN (CONTINUED)			TREATMENT SUMMARY (CONTINUED)
Non-chemotherapeutic Agents	Route	Purpose/Goal	Comments

<b>Reason for stopping treatment:</b> <input type="checkbox"/> Completion <input type="checkbox"/> Toxicity <input type="checkbox"/> Progression <input type="checkbox"/> Other: _____	<b>Response to treatment:</b> <input type="checkbox"/> Complete <input type="checkbox"/> Partial <input type="checkbox"/> No response <input type="checkbox"/> Progression <input type="checkbox"/> Not measurable
<b>Treatment-related hospitalization required:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Serious toxicities during treatment (list all):</b>
<b>Ongoing toxicity at completion of treatment:</b> <input type="checkbox"/> Yes (enter type(s) and grade(s) _____) <input type="checkbox"/> No	

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

<b>Radiation therapy:</b> <input type="checkbox"/> Not planned <input type="checkbox"/> Planned <input type="checkbox"/> Administered	Region treated: _____ Date initiated: ( / / )	Radiation dose: _____ Date completed: ( / / )
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ONCOLOGY TEAM MEMBER CONTACTS	SURVIVORSHIP CARE PROVIDER CONTACTS
<b>Provider:</b>	<b>Provider:</b>
Name:	Name:
Contact Info:	Contact Info:
<b>Provider:</b>	<b>Provider:</b>
Name:	Name:
Contact Info:	Contact Info:
<b>Provider:</b>	<b>Provider:</b>
Name:	Name:
Contact Info:	Contact Info:
<b>Provider:</b>	<b>Provider:</b>
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:**

<p><b>Needs or concerns:</b></p> <p><input type="checkbox"/> Prevention and wellness: _____</p> <p><input type="checkbox"/> Genetic risk: _____</p> <p><input type="checkbox"/> Emotional or mental health: _____</p> <p><input type="checkbox"/> Personal relationships: _____</p> <p><input type="checkbox"/> Fertility: _____</p> <p><input type="checkbox"/> Financial advice or assistance: _____</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Referrals provided:</b></p> <p><input type="checkbox"/> Dietician</p> <p><input type="checkbox"/> Smoking cessation counselor</p> <p><input type="checkbox"/> Physical therapist or exercise specialist</p> <p><input type="checkbox"/> Genetic counselor</p> <p><input type="checkbox"/> Psychiatrist</p> <p><input type="checkbox"/> Psychologist</p> <p><input type="checkbox"/> Social worker</p> <p><input type="checkbox"/> Fertility specialist or endocrinologist</p> <p><input type="checkbox"/> Other: _____</p>
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**Comments**