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| **General Information** | | | | | | |
| Patient Name: | | Patient DOB: | | | | |
| Patient phone: | | Email: | | | | |
| **Health Care Providers** (Including Names, Institution, Phone numbers) | | | | | | |
| Primary Care Provider: | | | | | | |
| Surgeon: | | | | | | |
| Radiation Oncologist: | | | | | | |
| Medical Oncologist: | | | | | | |
| Other Providers (Navigator): | | | | | | |
| **Diagnosis** | | | | | | |
| Cancer Type/Location/Histologic type: | | | Diagnosis Date: | | | |
| **T**umor size: Lymph **N**odes:  **M**etastasis:  Stage: ☐I ☐II ☐III ☐IV ☐Not available/applicable  Other information about the cancer: | | | | | | |
| **Treatment Plan** | | | | | | |
| **Treatment Goal:** ☐To cure the cancerand relieve symptoms and side effects of treatment  ☐ To slow the growth of the cancer and relieve symptoms and side effects of treatment | | | | | | |
| **Treatment Plan** | | | | | | |
| Surgery ☐ Yes ☐No | Surgery Date(s) (year): | | | Procedure/location: | | |
| Radiation ☐ Yes ☐No | Body area to be treated: | | | How many treatments over how many weeks: | | |
| Systemic Therapy (chemotherapy, hormonal therapy, other) ☐ Yes ☐No | | | | | | |
| To be given *before* surgery or radiation (neoadjuvant) ☐ Yes ☐No | | | | | | |
| Name of regimen and agents used: | | | | | Number of cycles planned and frequency: | |
| To be given *after* surgery or radiation (adjuvant) ☐ Yes ☐No | | | | | | |
| Name of regimen and agents used: | | | | | Number of cycles planned and frequency: | |
| Additional information: | | | | | |

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| **Symptoms or Side Effects** |
| Symptoms or side effects common ***during*** your treatments:  ☐Allergic reactions ☐ Muscle/bone pain or soreness  ☐Diarrhea/constipation ☐Nausea/vomiting  ☐Fatigue or being tired ☐Numbness and tingling in hands/feet  ☐Hair loss ☐Skin changes  ☐Heart damage ☐Trouble thinking  ☐Infection/fever ☐Trouble breathing  ☐Low blood counts ☐Urinary symptoms  ☐Mouth sores 🞏 Other: |
| Please let us know if you have:   1. A fever over 100.5F 2. A brand new symptom; 3. A symptom that doesn’t go away; 4. Anything you are worried about that might be related to the cancer or treatment. |
| **Other Concerns** |
| People with cancer may have issues with the areas listed below. If you have any concerns, please speak with your doctors or nurses to find out how you can get help with them.  ☐Emotional and mental health ☐Insurance ☐School/work ☐Other  ☐Fatigue ☐Memory or concentration loss ☐Sexual Functioning  ☐Fertility ☐Parenting ☐Stopping Smoking  ☐Financial advice or assistance ☐Physical functioning ☐Weight changes |
| A number of lifestyle/behaviors can affect your ongoing health, including the risk for the cancer coming back or developing another cancer. Discuss these recommendations with your doctor or nurse:  ☐Alcohol use ☐Physical activity ☐Tobacco use/cessation ☐Other  ☐Diet ☐Sun screen use ☐Weight management (loss/gain) |
| Please note that it is important that you continue to see your primary care provider for your other health care needs throughout your treatment. When your treatment is done, we will give you a survivorship care plan that outlines what happens after treatment is over. |
| Resources you may be interested in:   * [www.cancer.net](http://www.cancer.net) * Other: |
| Other comments: |
| Prepared by: Delivered on: |