The Minnesota Cancer Alliance is pleased to provide this survivorship care plan: *What’s Next? Life After Cancer Treatment*. This booklet is a road map of sorts, a way to help you record where you’ve been and provide information to help you plan the next part of your cancer journey.

This booklet is designed to help you:

- create a concise history of your cancer treatment experience
- provide a platform for dialog with your care providers
- manage your follow-up medical care
- gain an awareness of side effects in both the short and long-term
- provide tools and direction for self-care involving physical, emotional and practical issues

Karen Karls is a cancer survivor from Grand Rapids, Minnesota. She has some thoughts to share on cancer and the use of this booklet.

*It’s cancer.*

_The words set your world spinning and fill you with fear. Soon your life is centered on doctors, tests, and treatments. You learn what comes next and who to go to with questions._

_Then comes your last big treatment, and you are left wondering, What next?_

*A survivor care plan would have helped me with this question. A care plan is a history of your cancer journey. It is a place to note the stages of your treatment, long-term side effects and what to expect from your follow-up care._

_It’s been 11 years for me, and the exact treatment dates have faded from my memory. With a care plan, I can find these details without having to go through all of my records._

*A survivor care plan is for the future – an empowering reminder that you still have control of your life. Cancer happened to you, but it does not have to define who you are._

– Karen Karls
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SUMMARY OF CANCER TREATMENT

Having detailed information about the cancer treatment you receive is important.

Use this section to write notes about your diagnosis, treatment, and care team. This will be useful to future doctors and others who may need to know your cancer history.

Please update this section as you learn more details about your cancer journey.

Every person’s cancer experience is different, so parts of the booklet may not apply to you.
**PERSONAL INFORMATION:**

Name ____________________________________________

Address ____________________________________________

Phone ____________________________________________

Date of birth ____________________________________________

**People who supported me through my diagnosis and treatment:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Phone</th>
<th>Signed a “release of information” form?*Note</th>
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</thead>
<tbody>
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</tbody>
</table>

*Note if you signed a form that gives this person access to your medical records, this form needs to be renewed every year.

I have completed a Health Care Directive: ☐Yes ☐No

Where my Health Care Directive is located ____________________________

A Health Care Directive (also known as a Living Will or Durable Power of Attorney for Health Care) is designed to assist a person in communicating their wishes about health care, should they be unable to make or communicate decisions. It is a document in which a person may name someone to make decisions for them and/or provide information about care they would or would not like to receive in the event that they cannot speak for themselves.
# PEOPLE IN MY FAMILY WITH CANCER

<table>
<thead>
<tr>
<th>Relative</th>
<th>Name</th>
<th>Type of cancer</th>
<th>Age at diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother’s father</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Father’s mother</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Father’s father</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>

## GENETIC COUNSELING

Genetic testing will tell you if cancer runs in your family. Most cancers do not run in the family. Only a small number of people will need genetic counseling.

Did my care team suggest genetic counseling?  
- [ ] Yes  
- [ ] No  

I received genetic counseling.  
- [ ] Yes  
- [ ] No  

If yes:
1. Date I met with the genetic counselor: ____________________________
2. Type of genetic test I had: ____________________________
3. Date of test: ____________________________
4. Results of test: ____________________________
MEDICAL CARE TEAM

General Care
Family doctor ________________________________
Office or clinic name __________________________
Address _______________________________________
_____________________________________________
Phone ___________________ Fax __________________

Cancer Surgery
Cancer surgeon _______________________________
Office or clinic name __________________________
Address _______________________________________
_____________________________________________
Phone ___________________ Fax __________________

Cancer Care
Cancer doctor (oncologist) _______________________
Nurses ________________________________________
Office or clinic name __________________________
Address _______________________________________
Phone ___________________ Fax __________________
MEDICAL CARE TEAM

Radiation
Radiation doctor ________________________________

Nurses ________________________________

Office or clinic name ________________________________

Address ________________________________

__________________________________

Phone ________________________________ Fax ________________________________

Other Specialist
Name and title ________________________________

Office or clinic name ________________________________

Address ________________________________

__________________________________

Phone ________________________________ Fax ________________________________

Hospital or Clinic
Hospital or clinic name ________________________________

Address ________________________________

__________________________________

Phone ________________________________ Fax ________________________________
**MEDICAL CARE TEAM**

**Hospital or Clinic**

Hospital or clinic name_________________________________________________________

Address ____________________________________________________________

___________________________________________________________________________

Phone __________________________ Fax ______________________________

<table>
<thead>
<tr>
<th>Other Care Providers</th>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
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<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
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<tr>
<td>Dietician</td>
<td></td>
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<tr>
<td>Genetic counselor</td>
<td></td>
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<tr>
<td>Physical therapist</td>
<td></td>
<td></td>
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<tr>
<td>Spiritual advisor</td>
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<tr>
<td>Rehabilitation therapist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complementary and Alternative Medicine care providers (chiropractor, acupuncturist, massage therapist, etc.)</td>
<td></td>
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<tr>
<td>Other(s)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CANCER DIAGNOSIS

Type of cancer______________________________________________________

Date I learned I had cancer _________________ Stage ______________

Hospital or clinic that found the cancer______________________________

Comments _______________________________________________________________________________________

I have a copy of my pathology report: ☐ Yes ☐ No

Where my pathology report is located ______________________________________

CANCER TREATMENT SUMMARY

Some of the treatments may not apply to you.

1st Surgery

Type of surgery______________________________________________________

Date of surgery ______________________________________________________

Where surgery was done ______________________________________________

Doctor who did the surgery _____________________________________________

Describe any problems you had after surgery____________________________

____________________________________________________________________

____________________________________________________________________

I have a copy of my surgery record: ☐ Yes ☐ No
CANCER TREATMENT SUMMARY

2nd Surgery
Type of surgery ____________________________________________

Date of surgery ____________________________________________

Where surgery was done _____________________________________

Doctor who did the surgery _________________________________

Describe any problems you had after surgery __________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

I have a copy of my surgery record: ☐ Yes ☐ No

3rd Surgery
Type of surgery ____________________________________________

Date of surgery ____________________________________________

Where surgery was done _____________________________________

Doctor who did the surgery _________________________________

Describe any problems you had after surgery __________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

I have a copy of my surgery record: ☐ Yes ☐ No
CANCER TREATMENT SUMMARY

1st Course of Radiation
Where I received treatments ____________________________________________

Dates: from __________________ to ____________________________

Area of body treated _____________________________________________

Number of treatments _______________ Total dose _______________

Describe any problems you had from the radiation ________________

________________________________________________________________

________________________________________________________________

2nd Course of Radiation
Where I received treatments ____________________________________________

Dates: from __________________ to ____________________________

Area of body treated _____________________________________________

Number of treatments: _______________ Total dose _______________

Describe any problems you had from the radiation ________________

________________________________________________________________

________________________________________________________________

I have a copy of my radiation therapy summary: ☐Yes  ☐No
CANCER TREATMENT SUMMARY

Port Information
Hospital where port was placed

Date port was placed

Area of body

Type of port (brand and company)

Describe any problems you had with the port

I have a copy of my port information: ☐ Yes ☐ No

Clinical Trial Information
You may join a clinical trial at any point in your cancer journey.

Name of clinical trial

Dates of trial

Hospital or clinic where trial was done

Name of contact person

Describe any problems after the trial

I have a copy of the details from my clinical trial: ☐ Yes ☐ No
**CANCER TREATMENT SUMMARY**

Chemotherapy, Biotherapy, Hormone Therapy  
(and other drugs received as part of my cancer treatment)

Where I received therapy______________________________

<table>
<thead>
<tr>
<th>Drug name</th>
<th>How often</th>
<th>Start date</th>
<th>End date</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
## CANCER TREATMENT SUMMARY

### Chemotherapy, Biotherapy, Hormone Therapy

*Describe any bad reactions or problems from treatments*

---

---

I have a copy of my therapy records:  
☐ Yes  ☐ No

### Bone Marrow or Cord Blood Transplant

Type of transplant:

- ☐ Autologous (you received cells that you donated)
- ☐ Allogeneic (you received cells that someone else donated)

Hospital name ____________________________________________

Date of transplant _______________________________________

### Other Procedures and Treatments

<table>
<thead>
<tr>
<th>Name</th>
<th>Hospital or clinic</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood transfusion (red cells or platelets)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Biopsy</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
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</tbody>
</table>
AFTER TREATMENT CARE

This section explains the care you will need after you finish your cancer treatment. It lists questions you may want to ask your doctors. It also helps you think about the support you might need as a cancer survivor.

After your treatment ends, you will still see your doctor for regular care. You should know:

• What tests and clinic visits you will need
• How often you will need them
• Where to go for tests and exams

Many patients visit their cancer doctor every few months for several years. During clinic visits, your care team will check your health and answer your questions.
**AFTER TREATMENT CARE**

**Long-term Issues**

Ask your doctor what side effects you might have after your treatment has stopped:

<table>
<thead>
<tr>
<th>□ Appetite (hunger) changes</th>
<th>□ Breathing problems</th>
<th>□ Bone pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Change in concentration</td>
<td>□ Dental concerns</td>
<td>□ Change in ability to have children (fertility)</td>
</tr>
<tr>
<td>□ Headaches</td>
<td>□ Hearing changes</td>
<td>□ Heart problems</td>
</tr>
<tr>
<td>□ Hormone changes</td>
<td>□ Low energy</td>
<td>□ Memory changes</td>
</tr>
<tr>
<td>□ Pain</td>
<td>□ Sadness</td>
<td>□ Sexual health changes</td>
</tr>
<tr>
<td>□ Skin changes</td>
<td>□ Changes in sleep patterns</td>
<td>□ Swollen arms or legs (lymphedema)</td>
</tr>
<tr>
<td>□ Urinary problems</td>
<td>□ Worry</td>
<td>□ Numbness of hands or feet</td>
</tr>
<tr>
<td>□ Other (list)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
AFTER TREATMENT CARE

Questions to Ask

How long can side effects last after treatment has stopped?

Who should I call if I have any of these side effects?

How can I manage these side effects?

Other
## AFTER TREATMENT CARE

<table>
<thead>
<tr>
<th></th>
<th>How often should I see my doctor?</th>
<th>Purpose of visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family doctor</td>
<td></td>
<td></td>
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<tr>
<td>Cancer doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon</td>
<td></td>
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<tr>
<td>Other specialist(s)</td>
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</tbody>
</table>

### Comments

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

**Now that I am finished with my cancer treatment:**

When should I call my cancer doctor (oncologist)?  
____________________________________________________________________
____________________________________________________________________

When should I call my family doctor?  
____________________________________________________________________
____________________________________________________________________

When should I call other doctors or care providers involved in my care?  
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
AFTER TREATMENT CARE

Scans and X-rays (MRIs, PET Scans, CT Scans, etc.)
Which tests will I need, and how often?_____________________________________
_____________________________________________________________________
Who will order the tests?_______________________________________________
Dates of tests_________________________________________________________
How will I get my test results?___________________________________________

Lab tests & blood draws
Which tests will I need, and how often?___________________________________
_____________________________________________________________________
Who will order the tests?_______________________________________________
Dates of tests_________________________________________________________
How will I get my test results?___________________________________________

Other After-Treatment Tests
Which tests will I need, and how often?___________________________________
_____________________________________________________________________
Who will order the tests?_______________________________________________
Dates of tests_________________________________________________________
How will I get my test results?___________________________________________
AFTER TREATMENT CARE

Advice from Your Care Team

☐ Screening tests (to check for cancer):

☐ Eating habits:

☐ Exercise – what kind should I do?

☐ Healthy weight programs:

☐ Sunscreen:

☐ Immunizations:

☐ Help to quit smoking and tobacco:

☐ Support groups:

☐ Counseling (individual, couples, family):

☐ Sleep:

☐ Complementary and alternative medicine:

☐ Preventing osteoporosis (weak bones):

☐ Other:
## After Treatment Care

### Other Concerns

Below is a list of topics to think about after you finish treatment.

<table>
<thead>
<tr>
<th>Topic</th>
<th>My concern</th>
<th>Person who can help</th>
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</thead>
<tbody>
<tr>
<td>My relationships</td>
<td></td>
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<tr>
<td>Legal issues</td>
<td></td>
<td></td>
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<tr>
<td>Spiritual issues</td>
<td></td>
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<tr>
<td>Money problems</td>
<td></td>
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<tr>
<td>My job</td>
<td></td>
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<tr>
<td>My rights at work</td>
<td></td>
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<tr>
<td>Financial (money) planning</td>
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<tr>
<td>Estate planning</td>
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<tr>
<td>Long-term care</td>
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<td>Health insurance</td>
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<tr>
<td>Nutrition</td>
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<tr>
<td>Emotional support</td>
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<tr>
<td>Health changes</td>
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<tr>
<td>Lifestyle changes</td>
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<tr>
<td>Fear of cancer return (recurrence)</td>
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<tr>
<td>Other</td>
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RESOURCES

American Cancer Society  1-800-227-2345
www.cancer.org

Cancer Survivors Network  www.acscsn.org

National Cancer Institute  1-800-4-CANCER  [1-800-422-6237]
www.cancer.gov

Life After Cancer Treatment
www.cancer.gov/cancertopics/life-after-treatment

Notes