Cancer Survivor Care Plan

What's Next?
Life After Cancer Treatment

a project of:
minnesota cancer alliance
WORKING TOGETHER TO ELIMINATE THE BURDEN OF CANCER

A cancer diagnosis and subsequent treatment can be all-consuming. Your life is filled with appointments, care providers, and protocol; you know what comes next and who to go to with questions. Then you celebrate your last big treatment and are left wondering, what next? A survivor care plan would have helped me with that answer. It provides an organized place to note possible long-term side effects, and helps you know what to expect in follow-up care and how care fits into the big picture of "the rest of your life." A survivor care plan is a concise history of your cancer journey. It's been nearly 10 years for me and the exact treatment dates have faded from my memory. This would be a handy way of having those details without going through all of my records. The words, "It's cancer," set your world spinning and fills it with fear.

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
Cancer Survivor, Grand Rapids

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SUMMARY OF CANCER TREATMENT

Even though you may know many of the details of your cancer treatment as you go through the experience, the details may start to fade once you complete treatment and move on to another phase of your life.

This section will help you record the highlights of your cancer diagnosis and treatment, as well as contact information of physicians and other health care providers who have cared for you. The information will be a useful summary for you as well as for future doctors and other health care providers who may need information about your cancer history.

It would be helpful for you to continually update this information as it becomes available to you.

PERSONAL INFORMATION:

Name: _____

Address: _____

_____

Phone: _____

Date of Birth: _____

Family members and others who have supported me through my cancer diagnosis and treatment:

Name:	Relationship	Phone	Release of information form signed?*

* Indicate if you signed a form to allow this person to access your medical records.

I have completed a health care directive: ☐ Yes ☐ No

Cancer in My Family

Relative	Name	Type of Cancer	Age at Diagnosis
Mother			
Father			
Sibling			
Sibling			
Mother's Mother			
Mother's Father			
Father's Mother			
Father's Father			
Child			
Other			

Genetic Counseling*

*Genetic testing will tell if you and your family are genetically more likely to get cancer.

Was genetic counseling recommended for me? ☐ Yes ☐ No

I received genetic counseling ☐ Yes ☐ No

If yes:

1. Date I met with the genetic counselor _____

2. Type of genetic test recommended _____

_____

3. Date test was done _____

4. Results of genetic test _____

_____

Medical Care Providers

Primary Care

Primary Care Provider: _____

Office/Clinic Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Cancer Surgery

Cancer Surgeon: _____

Office/Clinic Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Cancer Care

Cancer Doctor: _____

Cancer Nurses: _____

Office/Clinic Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Medical Care Providers

Radiation

Radiation Oncologist: _____

Nurses: _____

Office/Clinic Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Other Specialist

Name/Title: _____

Office/Clinic Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Hospital/Facility #1

Hospital Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Medical Care Providers

Hospital/Facility #2

Hospital Name: _____

Address: _____

Phone: (_____)_____ Fax: (_____)_____

Other Care Providers

Name/Title	Facility	Phone
Social Worker		
Psychologist/Psychiatrist		
Dietician		
Genetic Counselor		
Physical Therapist		
Spiritual Support		
Rehabilitation		
Complementary Alternative Medicine (i.e. Chiropractor, Acupuncturist, Massage Therapist, etc.)		
Other		

Cancer Diagnosis

Diagnosis: _____

Date of Diagnosis: _____ Stage: _____

Facility where diagnosis was made: _____

Initial Symptoms: (that led to diagnosis): _____

_____

Comments: _____

_____

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

Cancer Treatment Summary

Surgery #1:

Surgical Procedure: _____

Date of Surgery: _____

Facility where surgery was done: _____

Name of Surgeon: _____

Describe any complications after surgery _____

_____

_____

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

Cancer Treatment Summary

Surgery #2:

Surgical Procedure: _____

Date of Surgery: _____

Facility where surgery was done: _____

Name of Surgeon: _____

Describe any complications after surgery _____

_____

_____

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

Surgery #3:

Surgical Procedure: _____

Date of Surgery: _____

Facility where surgery was done: _____

Name of Surgeon: _____

Describe any complications after surgery _____

_____

_____

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

Cancer Treatment Summary

Radiation Therapy- Course # 1

Facility where treatments were received: _____

From: (date) _____ To: (date) _____

Area of Body Treated _____

# of Treatments Received _____Total Dose Received _____

Describe any complications from radiation therapy treatments

_____

_____

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

Radiation Therapy- Course # 2

Facility where treatments were received: _____

From: (date) _____ To: (date) _____

Area of Body Treated _____

# of Treatments Received _____Total Dose Received _____

Describe any complications from radiation therapy treatments

_____

_____

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

Cancer Treatment Summary

Port Information

Facility where port was placed: _____

Date port placed: _____

Area of body where port is located: _____

Brand/company/kind of port: _____

Describe any complications from Port: _____

_____

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

Clinical Trial Information:

Name of Clinical Trial: _____

Dates of trial: _____

Facility where trial was done: _____

Name of trial contact person: _____

Describe any complications after trial: _____

_____

I have a copy of my clinical trial information: ☐ Yes ☐ No

*Patients can consider joining clinical trials at any point in their cancer journey.

Cancer Treatment Summary

Chemotherapy/Biotherapy/Hormonal Therapy
(and other pertinent drugs received as part of my cancer treatment)

Facility where chemotherapy/biotherapy was administered:

_____

Drug Name	Frequency	Start Date	End Date	Stopped due to side effects

Cancer Treatment Summary

Chemotherapy/Biotherapy/Hormonal Therapy

Describe any bad reactions or complications from treatments (including drugs):

_____

_____

I have a copy of my chemotherapy/ biotherapy/hormonal therapy records: ☐ Yes ☐ No

Bone Marrow or Cord Blood Transplant

Type of transplant (autologous or allogeneic) _____

Who did you receive the cells from? (self, related, unrelated)

_____

Hospital name _____

Date of infusion _____

Other Procedures/Treatments

Procedure	Facilities	Dates
Blood Transfusions (red cells or platelets)		
Dialysis		
Biopsy		
Other		

POST-TREATMENT FOLLOW-UP CARE

This section is intended to help you understand what care is recommended after you have finished your cancer treatment, and offer you ideas of what questions you may want to ask your doctor at this point in time.

It is important to know what kind of appointments and tests you will need, how often, and who should follow you for different health care needs as you finish your cancer treatment.

The focus of these visits is to monitor your overall health as it relates to your cancer and previous treatments. It is also a time to monitor for signs and symptoms of cancer recurrence. Many patients are followed by their cancer care provider on a regular basis for several years.

In addition, this section will help you think about support needs you may have as you move to the next phase of cancer survivorship.

Post-Treatment Follow-Up Care

Long-Term Medical/Psychosocial Issues

Ask your cancer care provider what side effects are possible after your treatment has stopped:

☐ Lack of Energy	☐ Hormone Changes	☐ Dental
☐ Heart Problems	☐ Breathing Problems	☐ Bone Pain
☐ Urinary	☐ Skin Changes	☐ Hearing
☐ Headaches	☐ Worry	☐ Sadness
☐ Appetite	☐ Concentration	☐ Memory
☐ Sleep	☐ Pain	☐ Sexual Health

☐ Swelling of arms/legs (Lymphedema)

☐ Ability to have children (Fertility)

☐ Fear of cancer return (Reccurrence)

☐ Other (list) _____

_____

_____

_____

_____

_____

_____

Follow-Up Care Questions to Ask

How long can side effects last after treatment has stopped?

_____

_____

_____

Who do I contact if I have any of these side effects?

_____

_____

_____

Recommended self-care strategies:

_____

_____

_____

Other:

_____

_____

_____

Post-Treatment Follow-Up Care

	How often do I need follow-up appointments with a doctor related to my cancer?	Purpose of appointment?
Primary Care Provider		
Cancer Care Provider		
Surgeon		
Other Specialist		

Now that I am finished with my cancer treatment:

What issues should I direct to my cancer care provider?

_____

What issues should I direct to my primary care provider?

_____

What issues should I refer to other specialists involved in my care?

_____

Post-Treatment Follow-Up Care

Follow-Up Tests

Which specific tests will I need and how often?

_____

Who will order the test(s)?

_____

Who will provide test results?

_____

Date of test?

_____

Medical Imaging,Tests (X-rays, MRI, PET Scan, CT Scan, etc.)

Which specific tests will I need and how often?

_____

Who will order the test(s)?

_____

Who will provide test results?

_____

Date of test?

_____

Lab Tests/Blood Draws

Which specific tests will I need and how often?

_____

Who will order the test(s)?

_____

Who will provide test results?

_____

Date of test?

_____

Other

Which specific tests will I need and how often?

_____

Who will order the test(s)?

_____

Who will provide test results?

_____

Date of test?

_____

Post-Treatment Follow-Up Care

Health Recommendations from Your Care Provider:

☐ Cancer Screenings: _____

_____

☐ Diet: _____

_____

_____

☐ Exercise: What type is recommended? _____

_____

_____

☐ Healthy Weight Programs: _____

_____

_____

☐ Sunscreen Use: _____

_____

☐ Immunizations: _____

_____

☐ Tobacco Cessation Classes: _____

_____

☐ Support Groups: _____

_____

_____

☐ Counseling: (Individual, Couples, Family) _____

_____

☐ Self-Care Strategies: _____

_____

_____

☐ Sleep: _____

_____

☐ Complementary Alternative Medicines: _____

_____

_____

☐ Osteoporosis Prevention: _____

_____

☐ Others _____

_____

_____

_____

Post-Treatment Follow-Up Care

Other Potential Concerns:
This is a tool to help you address areas that you may not think about while undergoing treatment for your cancer, but may start thinking about when you have finished treatment.

Concern	This is a concern	Name of person to help
Relationship changes		
Legal issues		
Spiritual issues		
Financial hardship		
Employment concerns		
Employment rights		
Financial planning		
Estate planning		
Long-term care		
Health insurance issues		
Nutritional issues		
Emotional support		
Health modifications		
Lifestyle modifications		
Other		

Resources

National Survivorship Resources

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

Cancer Survivors Network
http://csn.cancer.org

National Cancer Institute 1-800-4-CANCER
www.cancer.gov

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

What other resources do my care providers recommend?

_____

_____

_____

Local Resources

MN Cancer Resources
www.MNCancerResources.org
Minnesota's first Web site offering local cancer resources and information for cancer patients, their caregivers and health care professionals, no matter where you live in the state.

What other local resources do my care providers recommend?

_____

_____

_____

Notes

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