

ASCO Treatment Summary and Survivorship Care Plan

General Information		
Patient Name:	Patient DOB:	
Patient phone:	Email:	
Health Care Providers (Including Names, Institution)		
Primary Care Provider:		
Surgeon:		
Radiation Oncologist:		
Medical Oncologist:		
Other Providers:		
Treatment Summary		
Diagnosis		
Cancer Type/Location/Histology Subtype:	Diagnosis Date (year):	
Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> Not applicable		
Treatment		
Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery Date(s) (year):	
Surgical procedure/location/findings:		
Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No	Body area treated:	End Date (year):
Systemic Therapy (chemotherapy, hormonal therapy, other) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of Agents Used	End Dates (year)	
Persistent symptoms or side effects at completion of treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (enter type(s)) :		
Familial Cancer Risk Assessment		
Genetic/hereditary risk factor(s) or predisposing conditions:		
Genetic counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No                      Genetic testing results:		
Follow-up Care Plan		
Need for ongoing (adjuvant) treatment for cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional treatment name	Planned duration	Possible Side effects
Schedule of clinical visits		
Coordinating Provider	When/How often	

## ASCO Survivorship Care Plan

*Updated based on consensus conference held on 9.27.13 and the ASCO Survivorship Committee*

Cancer surveillance or other recommended related tests																	
Coordinating Provider	What/When/How Often																
<p>Please continue to see your primary care provider for all general health care recommended for a (man) (woman) your age, including cancer screening tests. Any symptoms should be brought to the attention of your provider:</p> <ol style="list-style-type: none"> <li>1. Anything that represents a brand new symptom;</li> <li>2. Anything that represents a persistent symptom;</li> <li>3. Anything you are worried about that might be related to the cancer coming back.</li> </ol>																	
<p>Possible late- and long-term effects that someone with this type of cancer and treatment may experience:</p>																	
<p>Cancer survivors may experience issues with the areas listed below. If you have any concerns in these or other areas, please speak with your doctors or nurses to find out how you can get help with them.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Emotional and mental health</td> <td><input type="checkbox"/> Fatigue</td> <td><input type="checkbox"/> Weight changes</td> <td><input type="checkbox"/> Stopping smoking</td> </tr> <tr> <td><input type="checkbox"/> Physical Functioning</td> <td><input type="checkbox"/> Insurance</td> <td><input type="checkbox"/> School/Work</td> <td><input type="checkbox"/> Financial advice or assistance</td> </tr> <tr> <td><input type="checkbox"/> Memory or concentration loss</td> <td><input type="checkbox"/> Parenting</td> <td><input type="checkbox"/> Fertility</td> <td><input type="checkbox"/> Sexual functioning</td> </tr> <tr> <td><input type="checkbox"/> Other</td> <td></td> <td></td> <td></td> </tr> </table>		<input type="checkbox"/> Emotional and mental health	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Weight changes	<input type="checkbox"/> Stopping smoking	<input type="checkbox"/> Physical Functioning	<input type="checkbox"/> Insurance	<input type="checkbox"/> School/Work	<input type="checkbox"/> Financial advice or assistance	<input type="checkbox"/> Memory or concentration loss	<input type="checkbox"/> Parenting	<input type="checkbox"/> Fertility	<input type="checkbox"/> Sexual functioning	<input type="checkbox"/> Other			
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<p>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:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Tobacco use/cessation</td> <td><input type="checkbox"/> Diet</td> </tr> <tr> <td><input type="checkbox"/> Alcohol use</td> <td><input type="checkbox"/> Sun screen use</td> </tr> <tr> <td><input type="checkbox"/> Weight management (loss/gain)</td> <td><input type="checkbox"/> Physical activity</td> </tr> </table>		<input type="checkbox"/> Tobacco use/cessation	<input type="checkbox"/> Diet	<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Sun screen use	<input type="checkbox"/> Weight management (loss/gain)	<input type="checkbox"/> Physical activity										
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<p>Resources you may be interested in:</p>																	
<p>Other comments:</p>																	
Prepared by:	Delivered on:																

- This Survivorship Care Plan is a cancer treatment summary and follow-up plan is provided to you to keep with your health care records and to share with your primary care provider.
- This summary is a brief record of major aspects of your cancer treatment. You can share your copy with any of your doctors or nurses. However, this is not a detailed or comprehensive record of your care.