

# 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

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.



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## PERSONAL INFORMATION:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Date of birth \_\_\_\_\_

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

Name	Relationship	Phone	Signed a "release of information" form? *Note

*\*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.*

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## PEOPLE IN MY FAMILY WITH CANCER

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			

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## 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 \_\_\_\_\_

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## 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 \_\_\_\_\_

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## 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 \_\_\_\_\_



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## MEDICAL CARE TEAM

### Hospital or Clinic

Hospital or clinic name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

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

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## 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 \_\_\_\_\_

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## 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

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## 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

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# 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

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## 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

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## CANCER TREATMENT SUMMARY

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

Where I received therapy \_\_\_\_\_

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Drug name	How often	Start date	End date

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## CANCER TREATMENT SUMMARY

### Chemotherapy, Biotherapy, Hormone Therapy

*Describe any bad reactions or problems from treatments*

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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

Name	Hospital or clinic	Dates
Blood transfusion (red cells or platelets)		
Dialysis		
Biopsy		
Other		

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## 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.





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## AFTER TREATMENT CARE

### Long-term Issues

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

<input type="checkbox"/> Appetite (hunger) changes	<input type="checkbox"/> Breathing problems	<input type="checkbox"/> Bone pain
<input type="checkbox"/> Change in concentration	<input type="checkbox"/> Dental concerns	<input type="checkbox"/> Change in ability to have children (fertility)
<input type="checkbox"/> Headaches	<input type="checkbox"/> Hearing changes	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Hormone changes	<input type="checkbox"/> Low energy	<input type="checkbox"/> Memory changes
<input type="checkbox"/> Pain	<input type="checkbox"/> Sadness	<input type="checkbox"/> Sexual health changes
<input type="checkbox"/> Skin changes	<input type="checkbox"/> Changes in sleep patterns	<input type="checkbox"/> Swollen arms or legs (lymphedema)
<input type="checkbox"/> Urinary problems	<input type="checkbox"/> Worry	<input type="checkbox"/> Numbness of hands or feet
<input type="checkbox"/> Other (list)		

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## AFTER TREATMENT CARE

### Questions to Ask

How long can side effects last after treatment has stopped?

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

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How can I manage these side effects?

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Other

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## AFTER TREATMENT CARE

	How often should I see my doctor?	Purpose of visit
Family doctor		
Cancer doctor		
Surgeon		
Other specialist(s)		

**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?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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## 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? \_\_\_\_\_

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## 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: \_\_\_\_\_

\_\_\_\_\_

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## AFTER TREATMENT CARE

### Other Concerns

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

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

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# RESOURCES

American Cancer Society      1-800-227-2345  
[www.cancer.org](http://www.cancer.org)

Cancer Survivors Network  
[www.acscsn.org](http://www.acscsn.org)

National Cancer Institute      1-800-4-CANCER  
[www.cancer.gov](http://www.cancer.gov)      [1-800-422-6237]

Life After Cancer Treatment  
[www.cancer.gov/cancertopics/life-after-treatment](http://www.cancer.gov/cancertopics/life-after-treatment)

## Notes

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