Cancer Diagnosis and Treatment Plan

Record your diagnosis, treatment plan and the names and phone numbers of your cancer treatment team.

Name: _____

Date: _____

Cancer Diagnosis

Type: _____

Stage: _____

Grade: _____

			Other Contacts
Primary Physician:	**Office**	_____	
_____	**Exchange**	_____	
Oncologist:	**Office**	_____	
_____	**Exchange**	_____	
Nurse Practitioner		_____	
_____	Office	_____	
Radiologist:	**Office**	_____	
_____	**Exchange**	_____	
Nurse Practitioner		_____	
_____	Office	_____	
Surgeon:	**Office**	_____	
_____	**Exchange**	_____	
Nurse Practitioner		_____	
_____	Office	_____	

Name of Treatment Protocol: _____

Name of Clinical Trial: _____

Summary of Prescribed Treatment Plan

Chemotherapy

_____

_____

_____

_____

_____

_____

_____

_____

Radiation

_____

_____

_____

_____

_____

_____

_____

_____

Surgery

_____

_____

_____

_____

_____

_____

_____

_____

Chart II

Treatment Schedule

Name: ______________________________

Record your treatment, test and doctor appointments.

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Summary Of Current Medications

Name: _____

Medication Name	Dosage	Medication Purpose	Application Frequency	Prescribing Physician

List all prescription medications, over-the-counter medications, vitamins, herbal supplements, meal substitute drinks and protein drinks.

Questions to Ask in Treatment and Recovery

Chart IV

Ask questions to become a proactive participant in your treatment.

- How long have you treated cancer patients?
- Why should you be on my treatment team?
- Have you treated this type of cancer before?
- What success have you had with it?
- What is the survival rate?
- What treatment do you prescribe?
- Where was it developed and used?
- Why are you prescribing it?
- What are the past results?
- How long does treatment last?
- What are my treatment options and alternatives?
- What are the success rates of the treatment options and alternatives?
- What's the best treatment facility for this cancer?
- Should I get a second opinion?
- Who is the lead physician for my treatment?
- Does my health insurance limit coverage for treatment?
- Where do I learn more about my cancer and prescribed treatment?
- Why do I need these tests?
- What will the test results tell you?
- What do you see on the x-ray?
- What do the blood analysis numbers tell you?
- What should I look for?
- Will treatment damage other parts of my body?
- Can it damage other organs?
- What can I do to protect myself?
- Where would infection show up?
- How do I combat the side effects?
- How long will the side effects last?
- How will I know if the cancer has returned?
- Are we winning yet?

Journal of Physical Health

Date and record changes in your physical health, such as numbness, bleeding, weakness or other changes you experience, including changes in their intensity and frequency.

Date	Description of Physical Changes	Intensity Low to High 1 2 3 4 5	Frequency

Journal of Notes and Questions

Put an X under the topics your treatment notes and questions cover.

Resolved	Date: _____	Allergic Reaction	Bleeding	Caregiver	Emotions	Fatigue	Fear	Fever	Infections	Inoculations	Medication	Medical Expenses	Pain	Physical Health	Senses	Schedules	Side Effects	Sores	Specialists	Strength	Treatment	Other
	Note **1** Question																					
	Note **2** Question																					
	Note **3** Question																					
	Note **4** Question																					
	Note **5** Question																					
	Note **6** Question																					
	Note **7** Question																					
	Note **8** Question																					
	Note **9** Question																					
	Note **10** Question																					

Treatment Preparation Action Plan

Use this chart to prepare for treatment and to plan how you'll use the time.

Treatment Round _____ **Treatment Dates** _____ **Treatment Duration** _____

Pre-Treatment Preparation

Exercise _____
_____
_____

Meal _____
_____

Clothing _____
_____
_____

Medication _____
_____

Vitamins _____
_____
_____

Bodily Functions _____

Other _____
_____
_____
_____
_____

Pack for Treatment

Reading Material _____
Newspapers _____
Magazines _____
Books _____
Other _____

Food & Snacks _____
_____

Beverages _____

Hobby Supplies _____

Writing Supplies _____

Cell Phone _____

Computer _____

CD Player _____

Earphones _____

Portable TV _____

Radio _____

Other _____
_____
_____
_____

Activities During Treatment

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Medical Appointment Agenda

Use this chart to prepare for your oncology appointments.

Appointment Date: _____ **Time:** _____ **Physician:** _____

Purpose: _____ **Pre-appt. Time** _____

SUMMARY OF PHYSICAL HEALTH

Rank Side Effects: Low (1 2 3 4 5) High

Allergic Reaction _____	Diarrhea _____	Indigestion _____	Pain _____	Strength _____
Appetite Loss _____	Dizziness _____	Infection _____	Physical Health _____	Sweating _____
Bleeding _____	Dry Mouth _____	Inoculations _____	Rash _____	Swelling _____
Bruising _____	Dry Skin/Itching _____	Insomnia _____	Sensory Changes _____	Tearing _____
Burning Sensation _____	Emotions _____	Intestinal Gas _____	Shortness of Breath _____	Throat Irritation _____
Caregiver's Health _____	Energy Level _____	Joint/Muscle Pain _____	Side Effects _____	Tingling _____
Chemo Brain _____	Fatigue _____	Medical Expenses _____	Sense of Smell _____	Transportation _____
Chills _____	Fear _____	Medications _____	Sense of Taste _____	Treatment _____
Concentration _____	Fever _____	Mouth Sores _____	Sores _____	Vomiting _____
Constipation _____	Fluid Retention _____	Nail Changes _____	Stiffness _____	Wheezing _____
Coughing _____	Hair Loss _____	Nausea _____	Stomach Cramps _____	Other _____
	Headache _____	Numbness _____		

Questions

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Answers

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medical Appointment Agenda - Summary

Use this chart to record the results of every medical appointment.

Physician's Overall Medical Evaluation

Progress Report

Prescribed Next Steps

Journal of Treatment Side Effects

Chart IX

Page ____ of ____

Rank each side effect with the appropriate level of intensity. Summarize how you feel and write down any questions.

Rank Side Effects: Low (1 2 3 4 5) High

Date	Allergic Reaction	Appetite Loss	Bleeding	Bruising	Burning Sensation	Chemo Brain	Chills	Concentration	Constipation	Cough	Diarrhea	Dizziness	Dry Mouth	Dry Skin/Itching	Energy Level	Fatigue	Fever	Fluid Retention	Hair Loss	Headache	Indigestion	Infection	Insomnia	Intestinal Gas	Joint Pain	Mouth Sores	Muscle Pain	Nail Changes	Nausea	Rash	Shortness of Breath	Sense of Smell	Sense of Taste	Sores	Stiffness	Stomach Cramps	Strength	Sweating	Swelling	Tearing	Throat Irritation	Tingling & Numbness	Vomiting	Wheezing	Other Side Effects

Overall Health Summary

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Questions to Ask

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Resources

The following resources may help increase your knowledge and understanding of cancer, cancer treatments, statistics, trials, tests and other relevant information, including links to organizations that address specific cancers and treatments.

National Cancer Institute
Bethesda, MA
800-422-6237
cancer.gov

American Cancer Society
Atlanta, GA (home office)
800-227-2345
cancer.org

LIVESTRONG
Lance Armstrong Foundation
Austin, TX 75219
866-235-7205
livestrong.org

The Isopure Company
195 Engineers Road
Hauppauge, NY 11788
www.isopureplus.com

The Center for Cancer Care and Research
12855 North Forty Dr. Suite 200
St. Louis, MO 63141
314-628-1210
tcccr.com

The Wellness Community of Greater St. Louis
1058 Old Des Peres Rd.
St. Louis, MO 63131
314-238-2000
wellnesscommunitystl.org

CURE: Cancer Updates, Research & Education
(a quarterly publication of CURE Media Group, LP)
3102 Oak Lawn Avenue, Suite 610
Dallas, TX 75219
800-210-CURE (2873); 214-367-3500
curetoday.com and **curemediagroup.com**

Comprehensive resource of cancer websites
cancer.com

Antioxidant-rich Foods

Berry Fruits
Blackberries
Blueberries
Strawberries
Raspberries
Cherries
Cranberries

Citrus Fruits
Oranges
Kiwis
Pineapple
Red Grapefruit
Lemons
Limes

Other Fruits
Apples & Apricots
Mangos & Peaches
Prunes & Plums
Watermelon & Cantaloupe
Red Grapes
Tomatoes
Raisins

Beverages
Green & White Tea
Coffee
V-8 Juice
Dark Beer
Red Wine
Pomegranate Juice

Vegetables
Broccoli & Cauliflower
Brussels Sprouts
Spinach
Green & Red Peppers
Sweet Potatoes
Artichoke (Cooked)
Cabbage
Squash
Carrots
Pumpkin

Proteins
Fish & Shellfish
Chicken
Lean Red Meats
Calf's Liver
Beans
Eggs
Pecans & Walnuts
Almonds
Peanuts
Soy Nuts
Sunflower Seeds

Grains & Cereals
Whole Grains
Oatmeal
Barley
Rice
Rye
Flaxseed
Rice Cereal

Spices
Cinnamon
Oregano
Parsley
Paprika
Black Pepper
Honey

Chart XII

Meal Plan

	Breakfast	Morning Snack	Lunch	Afternoon Snack	Dinner	Bedtime Snack	Calories
Sunday Menu Total Calories							
Monday Menu Total Calories							
Tuesday Menu Total Calories							
Wednesday Menu Total Calories							
Thursday Menu Total Calories							
Friday Menu Total Calories							
Saturday Menu Total Calories							

Vitamins

You may want to include the following vitamins and supplements during treatment and recovery. Be sure to discuss your supplement choices with your doctor to avoid conflicts with your treatment regimen.

- Multivitamin (be sure it includes iron to help build red-blood cells)
- Vitamin A (people with cancer require higher-than-normal amounts of this antioxidant)
- Vitamin B-complex (aids liver function, helps build red blood cells and improves circulation)
- Vitamin E (a powerful antioxidant and cancer-fighting agent)
- Vitamin C (powerful cancer-fighting agent that promotes the production of interferon in the body)
- CoQ10 (improves cellular oxygenation).

Recovery Plan and Journal

Record your diagnosis, treatment plan and the names and phone numbers of your cancer treatment team.

Name: _____

Date: _____

Treatment Completion Date: _____

Cancer Diagnosis Date: _____

Type: _____

Stage: _____

Grade: _____

			Other Contacts
Primary Physician:	**Office**		
	Exchange		
Oncologist:	**Office**		
	Exchange		
Nurse Practitioner			
	Office		
Radiologist:	**Office**		
	Exchange		
Nurse Practitioner			
	Office		
Surgeon:	**Office**		
	Exchange		
Nurse Practitioner			
	Office		

Summary of Prescribed Treatment Plan

Chemotherapy Summary: _____

Radiation Summary: _____

Other Treatment Summary: _____

Surgery Summary: _____

Summary of Complications and Major Side Effects: _____

Recovery Plan and Journal

Recovery Follow-up Plan

	3 months	6 months	9 months	12 months
Observation & Surveillance for Recurrence				
Long-term & Late Effects Monitoring				
Secondary Cancer Surveillance				
Port Flush				
Additional Recommendations				

Recovery Journal

Nutrition Meals Calories Vitamins Protein Other				
Physical Requirements Exercise Workouts Other Activities				
Sleep				
Work				
Relaxation Activities				

Chart XV

Recovery Schedule

Name: ____________________________

Record your appointment schedule for follow-up tests, scans and reviews with your treatment team.

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat

Month:

Sun	Mon	Tues	Wed	Thurs	Fri	Sat