Breast Cancer Adjuvant Treatment Plan and Summary

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The Treatment Plan and Summary provide a brief record of major aspects of breast cancer adjuvant treatment. This is not a complete patient history or comprehensive record of intended therapies.

Patient name:	**Patient ID**:	**Race:**
Patient DOB: (___/___/___) **Age at diagnosis**:	**Patient phone**:	
Support contact name: **Relationship**:	**Support contact phone**:	

BACKGROUND INFORMATION

Family history: □ None □ 2nd degree relative □ 1st degree relative □ Multiple relatives		**BRCA 1/2**: □ Pos □ Neg
Previous Breast Cancer: □ Yes (___/___/___) Type: □ No	**Breast Atypia:** □ Yes (___/___/___) □ No	
Definitive breast surgery: **Date**:(___/___/___)**Type**: □ Lumpectomy □ Mastectomy □ Mastectomy/immediate recon		
# lymph nodes removed:	**# lymph notes positive**:	**Biopsy Date:** (___/___/___)
Axillary dissection: □ Yes (___/___/___) □ No	**Sentinel node biopsy**: □ Yes (___/___/___) □ No	
Notable surgical findings/comments:		**Surgical Margin Clear**: □ Yes □ No
Tumor type: □ Infiltrating ductal □ Infiltrating lobular □ DCIS □ Other:		**Tumor size:**
T stage: □Tis □T1 □T2 □T3 □T4a □T4b □T4c □T4d	**N stage**: □ N0 □ N1 □ N2 □ N3	**M Stage:** □ M0 □ M1
Pathologic stage: □ 0 □ I □ II □ III □ IV	**Oncotype DX recurrence score:**	**Breast:** □ Right □ Left □ Bilateral
ER status: □ Positive □ Negative	**PR status**: □ Positive □ Negative	**HER2 status**: □ Positive □ Negative
Major comorbid conditions:	**HRt use:** □ Yes □ No □ oophorectomy □ Hysterectomy	
Echocardiogram or MUGA result prior to chemotherapy (if obtained): EF= %		**Onset of Menses:** (___/___/___)
Onset of Menopause: □ Yes (___/___/___) □ No	**Smoking History:** □ No □ Yes/Current □Yes/Past Years:	

ADJUVANT TREATMENT PLAN

ADJUVANT TREATMENT SUMMARY

White sections to be completed prior to chemotherapy administration, shaded sections following chemotherapy

Height: in/cm	**Pre-treatment weight:** lb/kg	**Post-treatment weight:** lb/kg
Pre-Treatment BSA:	**Date last menstrual period**:(___/___/___)	**Date last menstrual period**: (___/___/___)
Name of regimen:		
Start Date: (___/___/___)		**End Date:** (___/___/___)
Treatment on clinical trial: □ Yes □ No	**Name of Clinical Trial(s):**	

Chemotherapy Drug Name	Route	Dose	Schedule	Dose reduction needed	Number of cycles administered
				□ Yes _____% □ No	
				□ Yes _____% □ No	
				□ Yes _____% □ No	
				□ Yes _____% □ No	

Side effects experienced:
□ Hair loss □ Nausea/Vomiting
□ Neuropathy □ Low blood count
□ Fatigue □ Menopause symptoms
□ Cardiac symptoms □ Cognitive
□ Other:

Anthracycline administered: □ **Doxorubicin** _____ mg/m^2
□ **Epirubicin** _____ mg/m^2

Serious toxicities during treatment (list all):

Allergic Events:

Hospitalization for toxicity during treatment: □ Yes □ No

Neurotoxicity that impairs activities of daily living: □ Yes □ No

Reason for stopping adjuvant treatment:

Adopted from American Society of Clinical Oncology Breast Cancer Treatment Summary
Important caution: this is a summary document whose purpose is to review the highlights of the breast cancer chemotherapy treatment plan for this patient. This does not replace information available in the medical record, a complete medical history provided by the patient, examination and diagnostic information, or educational materials that describe strategies for coping with breast cancer and adjuvant chemotherapy in detail. Both medical science and an individual's health care needs change, and therefore this document is current only as of the date of preparation. This summary document does not prescribe or recommend any particular medical treatment or care for breast cancer or any other disease and does not substitute for the independent medical judgment of the treating professional.

Version 2.0

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ENDOCRINE THERAPY

□None □Tamoxifen □Aromatase Inhibitor □Other	**Date endocrine therapy started (or to start)** (___/___/___)
Medication:	
Duration:	

TRASTUZUMAB (HERCEPTIN) THERAPY

Trastuzumab (Herceptin) planned: □Yes □ No	**Trastuzumab (Herceptin) prescribed**: □Yes □ No
Planned or completed dates of trastuzumab therapy: Start date (___/___/___) End date (___/___/___)	**Pre-trastuzumab ejection fraction**: %(___/___/___)
	Most recent ejection fraction: %(___/___/___)

Radiation Therapy Summary

Location	Beam Arrangement	Area	Mode	Tumor Dose Total	Dates of Rx From	To	# of Visits	Elapsed Days
		□ Local (breast)						
		□ Regional (nodes)						
	Partial Brst RXT: □Yes □ No							

Lymphedema: □ Yes □ No **Date**: (___/___/___)	**Breast Reconstruction:** □ Yes □ No **Date**: (___/___/___)

ONCOLOGY TEAM MEMBER CONTACTS	SURVIVORSHIP CARE PROVIDER CONTACTS
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:
Provider:	**Provider:**
Name:	Name:
Contact Info:	Contact Info:

Supportive and Survivorship Services

Survivorship Clinic Appointment Made: □ Yes □ No **Date**: (___/___/___)		**Provider Name**	**Phone Number**
Nutrition Services			
Genetic Services	□ Yes □ No **Date: (___/___/___)**		
Social Work/Psychology	□ Yes □ No **Date: (___/___/___)**		
Rehabilitation Services	□ Yes □ No **Date: (___/___/___)**		
Other Support Service(s)	□ Yes □ No **Date: (___/___/___)**		
Living Will: □ Yes □ No	**Advanced Directive:** □ Yes □ No		
Complementary Services (e.g. Yoga, Tai Chi):			
Survivorship Educational Materials Provided:			