PRIME® CLL Care Checklist

BACKGROUND INFORMATION	
Patient name:	Patient DOB: / /
Age at diagnosis:	Diagnosis date: / /
Is this a new cancer diagnosis or recurrence?	❑ New ❑ Recurrence (date: / /)
Treatment Status:	❑ Observation ❑ Active treatment ❑ Treatment complete, complete response (CR) ❑ Treatment complete, partial response (PR) ❑ Relapsed/refractory
Signs/Symptoms	
❑ Fevers	❑ Fatigue
❑ Night sweats	❑ Shortness of breath
❑ Weight loss	❑ Enlarged spleen
❑ Enlarged lymph nodes	❑ Other:
❑ Enlarged liver	
ECOG Performance Status ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4	
Cumulative Illness Rating Scale ❑ ≤ 6 ❑ > 6 Download Scale	
Patient Fitness ❑ Frail, significant comorbidities ❑ Adequate function status	
Comments from patient:	
Notes:	

ECOG Performance Status

0 = Full active, able to carry on all pre-disease performance without restriction.
1 = Full active, able to carry on all pre-disease performance without restriction.
2 = Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature (eg, light house work, office work).
3 = Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about > 50% of waking hours.
4 = Capable of only limited self-care, confined to bed or chair > 50% of waking hours.
5 = Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair.

Quality of life Assesment

(Modified from: Medical Outcomes Study [MOS] 20-Item Short-Form Health Survey [SF-20])

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is:					

	Yes, all of the time	Yes, most of the time	Yes, some of the time	Yes, a little of the time	No, none of the time
When you travel around your community, does someone have to assist you because of your health?					

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
During the past month, how often did you feel worn out?						
During the past month, did you have enough energy to do the things you wanted to do?						
During the past month, how was your health a worry in your life?						
During the past month, were you afraid because of your health?						
During the past month, how much of the time have you been anxious or worried?						
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (eg, visiting with friends, relatives, etc.)?						

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Never
During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (eg, visiting with friends, relatives, etc.)?						

Patient's greatest challenge in managing his/her CLL:	

Work Up

Study	Date	Findings
Flow cytometry		❑ Postive ❑ Negative
CD5		❑ Postive ❑ Negative
CD10		❑ Postive ❑ Negative
CD23		❑ Postive ❑ Negative
CD20dim		❑ Postive ❑ Negative
Bone marrow biopsy		❑ Lymphoma ❑ No lymphoma ❑ Indeterminate
Rai[1] stage:		❑ 0 ❑ I ❑ II ❑ III ❑ IV
(or) Binet[2] stage:		❑ A ❑ B ❑ C
Evaluation of Prognosis		
LDH level		❑ Low ❑ Normal ❑ High ❑ Not performed
ß2-microglobulin expression		❑ Low ❑ Normal ❑ High ❑ Not performed
FISH		❑ 13q deletion ❑ 11q deletion ❑ 17p deletion ❑ 12+ ❑ Normal ❑ Not performed
IGVH mutation status		❑ > 2% mutation ❑ ≤ 2% mutation ❑ Not tested
CD38 expression		❑ < 30% mutation ❑ ≥ 30% mutation ❑ Not tested
ZAP-70 expression		❑ < 20% mutation ❑ ≥ 20% mutation ❑ Not tested

INDICATIONS FOR TREATMENT

❑ Rai stages III or IV (Binet stage C)

❑ Rai stages 0, I, or II ***and***
❑ Significant disease-relate symptoms (severe fatigue, weight loss, night sweats, fever without infection)
❑ Threatened end-organ function
❑ Progressive bulky disease (spleen > 6 cm below costal margin, lymph nodes > 10 cm)
❑ Progressive anemia
❑ Progressive thrombocytopenia (> 100,000 cells/mm^3)

❑ Eligible ❑ Not eligible

Comments from patient:

Notes:

[1] Rai System

STAGE	DESCRIPTION	RISK STATUS
0	Lymphocytosis, lymphocytes in blood > 15,000 mcL and > 40% lymphocytes in bone marrow	Low
I	Stage 0 with enlarged node(s)	Intermediate
II	Stage 0–I with splenomegaly, hepatomegaly, or both	Intermediate
III	Stage 0–II with hemoglobin < 11.0 g/dL or hematocrit < 33%	High
IV	Stage 0–III with platelets < 100,000 mcL	High

[2] Binet System

STAGE	DESCRIPTION
A	Hemoglobin > 10 g/dL and platelets > 100,00/mm3 and < 3 enlarged areas
B	Hemoglobin > 10 g/dL and platelets > 100,00/mm3 and > 3 enlarged areas
C	Hemoglobin < 10 g/dL and platelets < 100,00/mm^3 and any number of enlarged areas

TREATMENT PLAN

Name of treatment regimen:

Number of planned cycles:

Chemotherapy start date:	Chemotherapy end date:
Pre-treatment weight:	Post-treatment weight:
ECOG performance status at start of treatment: ❑0 ❑1 ❑2 ❑3 ❑4	ECOG performance status after of treatment: ❑0 ❑1 ❑2 ❑3 ❑4

Major Side Effects of Regimen

❑ Nausea/vomitinge	❑ Infections
❑ Neutropenia	❑ Anemia
❑ Thrombocytopenia	❑ Leukopenia
❑ Neuropathy	❑ Fatigue
❑ Weight loss	❑ Cardiac
❑ Infusion-related reaction	❑ Other:

Response to Treatment

Reason for stopping treatment:	Response to therapy:
❑ Completed	❑ Complete
❑ Progression of disease on treatment	❑ Complete response, unconfirmed
❑ Toxicity of treatment	❑ Partial
❑ Comorbid illness	❑ Stable disease
❑ Other:	❑ Relapse/progression

Comments from patient:

Notes:

Patient Needs or Concerns

Patient's goal for treatment:

- ❑ Stopping their CLL from progressing
- ❑ Managing their symptoms
- ❑ Improving their ability to perform ADLs
- ❑ Preventing hospitalizations
- ❑ Prolong overall survival
- ❑ Other: _____

Referrals provided:

- ❑ Psychologist
- ❑ Psychiatrist
- ❑ Physical therapist or exercise specialist
- ❑ Dietician
- ❑ Smoking cessation counselor

Patient's overall care experience: _____

_____

Care Providers

Oncology Team Member Contacts

Oncology nurse (name): _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Radiologist nurse (name): _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Provider name: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Role: _____ Date: _____

Provider name: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Role: _____ Date: _____

Primary Care and Survivorship Care Provider Contacts

Primary care provider: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Case manager: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Provider/Specialty: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Provider/Specialty: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Provider/Specialty: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Provider/Specialty: _____ Contact Info: _____ Consulted: ❑ Yes ❑ No
Date: _____

Comments from patient: _____

Notes: _____

Preventive Care

Service	Date	Comments
❑ Influenza vaccine		
❑ Pneumococcal vaccine		
❑ Tobacco screening		

Care Management Plan Checklist

Does this patient's management plan include:

1. Assessment of patient's signs and symptoms..... ❑ Yes ❑ No
2. Assessment of patient's quality of life..... ❑ Yes ❑ No
3. Evaluation of prognosis..... ❑ Yes ❑ No
4. Management goals with which the patient agrees..... ❑ Yes ❑ No
5. Treatments and services the patient is likely to need..... ❑ Yes ❑ No
6. Discussion with patient about treatment preferences..... ❑ Yes ❑ No
7. Discussion with other providers about the care and services for the patient..... ❑ Yes ❑ No
8. Explanation to the patient (or caregiver) about the treatment..... ❑ Yes ❑ No
9. Documentation of treatment and service goals for the patient..... ❑ Yes ❑ No
10. Documentation of treatment and services that collaborating providers will provide to the patient..... ❑ Yes ❑ No
11. Date for follow-up..... ❑ Yes ❑ No

Comments from patient: _____

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Notes: _____

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References

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