

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

Breast Cancer Adjuvant Treatment Plan and Summary

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: <input type="checkbox"/> None <input type="checkbox"/> 2 nd degree relative <input type="checkbox"/> 1 st degree relative <input type="checkbox"/> Multiple relatives | | | | BRCA 1/2: <input type="checkbox"/> Pos <input type="checkbox"/> Neg | |
| Previous Breast Cancer: <input type="checkbox"/> Yes (___/___/___) Type: <input type="checkbox"/> No | | Breast Atypia: <input type="checkbox"/> Yes (___/___/___) <input type="checkbox"/> No | | | |
| Definitive breast surgery: Date: (___/___/___) Type: <input type="checkbox"/> Lumpectomy <input type="checkbox"/> Mastectomy <input type="checkbox"/> Mastectomy/immediate recon | | | | | |
| # lymph nodes removed: | | # lymph nodes positive: | | Biopsy Date: (___/___/___) | |
| Axillary dissection: <input type="checkbox"/> Yes (___/___/___) <input type="checkbox"/> No | | Sentinel node biopsy: <input type="checkbox"/> Yes (___/___/___) <input type="checkbox"/> No | | | |
| Notable surgical findings/comments: | | | | Surgical Margin Clear: <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Tumor type: <input type="checkbox"/> Infiltrating ductal <input type="checkbox"/> Infiltrating lobular <input type="checkbox"/> DCIS <input type="checkbox"/> Other: | | | | Tumor size: | |
| T stage: <input type="checkbox"/> Tis <input type="checkbox"/> T1 <input type="checkbox"/> T2 <input type="checkbox"/> T3 <input type="checkbox"/> T4a <input type="checkbox"/> T4b <input type="checkbox"/> T4c <input type="checkbox"/> T4d | | N stage: <input type="checkbox"/> N0 <input type="checkbox"/> N1 <input type="checkbox"/> N2 <input type="checkbox"/> N3 | | M Stage: <input type="checkbox"/> M0 <input type="checkbox"/> M1 | |
| Pathologic stage: <input type="checkbox"/> 0 <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV | | Oncotype DX recurrence score: | | Breast: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | |
| ER status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | | PR status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | | HER2 status: <input type="checkbox"/> Positive <input type="checkbox"/> Negative | |
| Major comorbid conditions: | | | HRt use: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> oophorectomy <input type="checkbox"/> Hysterectomy | | |
| Echocardiogram or MUGA result prior to chemotherapy (if obtained): EF= % | | | | Onset of Menses: (___/___/___) | |
| Onset of Menopause: <input type="checkbox"/> Yes (___/___/___) <input type="checkbox"/> No | | Smoking History: <input type="checkbox"/> No <input type="checkbox"/> Yes/Current <input type="checkbox"/> Yes/Past Years: | | | |
| ADJUVANT TREATMENT PLAN | | | ADJUVANT TREATMENT SUMMARY | | |
| <i>White sections to be completed prior to chemotherapy administration, shaded sections following chemotherapy</i> | | | | | |
| 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: <input type="checkbox"/> Yes <input type="checkbox"/> No | | Name of Clinical Trial(s): | | | |
| Chemotherapy Drug Name | Route | Dose | Schedule | Dose reduction needed | Number of cycles administered |
| | | | | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | |
| | | | | <input type="checkbox"/> Yes _____% <input type="checkbox"/> No | |
| Side effects experienced: | | | Anthracycline administered: <input type="checkbox"/> Doxorubicin _____ mg/m ² <input type="checkbox"/> Epirubicin _____ mg/m ² | | |
| <input type="checkbox"/> Hair loss <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Neuropathy <input type="checkbox"/> Low blood count <input type="checkbox"/> Fatigue <input type="checkbox"/> Menopause symptoms <input type="checkbox"/> Cardiac symptoms <input type="checkbox"/> Cognitive <input type="checkbox"/> Other: _____ | | | Serious toxicities during treatment (list all): | | |
| Allergic Events: | | | Hospitalization for toxicity during treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | Neurotoxicity that impairs activities of daily living: <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | | | Reason for stopping adjuvant treatment: | | |

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Breast Cancer Adjuvant Treatment Plan and Summary

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| ADJUVANT TREATMENT PLAN | | | | ADJUVANT TREATMENT SUMMARY | | | | |
|--|------------------|--|------|---|------------------|--------------|-------------|--------------|
| ENDOCRINE THERAPY | | | | | | | | |
| <input type="checkbox"/> None <input type="checkbox"/> Tamoxifen <input type="checkbox"/> Aromatase Inhibitor <input type="checkbox"/> Other | | | | Date endocrine therapy started (or to start) (___/___/___) | | | | |
| Medication: | | | | | | | | |
| Duration: | | | | | | | | |
| TRASTUZUMAB (HERCEPTIN) THERAPY | | | | | | | | |
| Trastuzumab (Herceptin) planned: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Trastuzumab (Herceptin) prescribed: <input type="checkbox"/> Yes <input type="checkbox"/> 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 |
| | | <input type="checkbox"/> Local (breast) | | | | | | |
| | | <input type="checkbox"/> Regional (nodes) | | | | | | |
| | | Partial Brst RXT: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | | |
| Lymphedema: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (___/___/___) | | | | Breast Reconstruction: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (___/___/___) | | | | Provider Name | | Phone Number | | |
| Nutrition Services | | | | | | | | |
| Genetic Services | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (___/___/___) | | | | |
| Social Work/Psychology | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (___/___/___) | | | | |
| Rehabilitation Services | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (___/___/___) | | | | |
| Other Support Service(s) | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No Date: (___/___/___) | | | | |
| Living Will: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | Advanced Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |
| Complementary Services (e.g. Yoga, Tai Chi): | | | | | | | | |
| Survivorship Educational Materials Provided: | | | | | | | | |

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