



Windsongbreastcare  
Compassion. Care. Commitment.

# *Survivor Care Plan*

To assist you in the transition from treatment to surveillance, we have included the following pages for you to record a summary of your survivor care plan.

Ask your healthcare team to help you complete any information you are unsure about.

This summary can be shared with future healthcare providers as needed.

## Healthcare Team Contact Information

	Name:	Contact Information:
Primary Care Physician		
Breast Surgeon		
Reconstructive Surgeon		
Medical Oncologist		
Radiation Oncologist		
Breast Health Navigator/ Nurse		
Genetic Counselor		
Psychotherapist		
Nutritionist		
Physical Therapist/Lymphedema		
Visiting Nurse		

Name: \_\_\_\_\_

DOB: \_\_\_ / \_\_\_ / \_\_\_\_\_

**Clinical Presentation****Date of Discovery:** \_\_\_ / \_\_\_ / \_\_\_\_\_ **Screening Facility:** \_\_\_\_\_

- Palpable mass  
 Radiology procedure If yes, finding(s):  Mass  Calcifications  Architectural distortion  
 Nipple Discharge  
 Other: \_\_\_\_\_

**Diagnostic Procedure****Date of Procedure:** \_\_\_ / \_\_\_ / \_\_\_\_\_**Procedure Type:**  FNA  US-guided core  Stereotactic  Other : \_\_\_\_\_**Initial Pathology:** \_\_\_\_\_

- Ductal carcinoma in situ       Mixed type carcinoma       Tubular carcinoma  
 Paget disease                       Mucinous carcinoma       Inflammatory carcinoma  
 Invasive ductal carcinoma       Medullary carcinoma       No residual carcinoma following  
 Invasive lobular carcinoma       Papillary carcinoma              neoadjuvant therapy

**ER/PR Status:**  ER Positive  PR Positive  ER Negative  PR Negative**HER2 Status:**  Positive  Negative**Surgical Management****Date of Surgery:** \_\_\_ / \_\_\_ / \_\_\_\_\_ **Facility:** \_\_\_\_\_**Location:**  Right Breast  Left Breast  Bilateral  Not indicated**Lymph Node Sampling:** Sentinel Node Biopsy If yes, results:  Node Negative  Node Positive, #: \_\_\_\_\_ Axillary Dissection If yes, results:  Node Negative  Node Positive, #: \_\_\_\_\_**Surgical Procedure:**

- Lumpectomy                       Modified radical mastectomy       Nipple or skin-sparing mastectomy  
 Partial mastectomy       Sentinel node biopsy               Contralateral prophylactic mastectomy  
 Simple mastectomy       Axillary node dissection               With reconstruction

**Tumor:** Size: \_\_\_\_\_  Could not be determined**Genetic Testing:**  No  Yes If yes, results:  Negative  Positive  Uncertain**Post-Treatment Precautions:**  No  Yes If yes, \_\_\_\_\_**Post-Treatment Contraindications:**  No  Yes If yes, \_\_\_\_\_

## Reconstructive Surgery

**Date of Surgery:** \_\_\_/\_\_\_/\_\_\_\_  Immediate  Delayed  Declined by patient  N/A

**Location:**  Right Breast  Left Breast  Bilateral

**Reconstruction Type:**

Saline Implant  Silicone Implant

Latissimus Dorsi  TRAM  Inferior Gluteus  TAP  DIEP  S-GAP  SIEA  I-GAP

Other: \_\_\_\_\_

## Surgical Pathology Summary

**Cancer Type:**

- Ductal carcinoma in situ  Mixed type carcinoma  Tubular carcinoma  
 Paget disease  Mucinous carcinoma  Inflammatory carcinoma  
 Invasive ductal carcinoma  Medullary carcinoma  No residual carcinoma following  
 Invasive lobular carcinoma  Papillary carcinoma neoadjuvant therapy

**ER/PR Status:**  ER Positive  PR Positive  ER Negative  PR Negative

**HER2 Status:**  Positive  Negative

**Final Pathology:** Stage: \_\_\_\_\_ pTNM/yTNM: \_\_\_\_\_ Comments: \_\_\_\_\_

## Medical Oncology

**Consult date:** \_\_\_/\_\_\_/\_\_\_\_

**Date Started:** \_\_\_/\_\_\_/\_\_\_\_ **Date Completed:** \_\_\_/\_\_\_/\_\_\_\_  Patient Declined

Standard therapy  Clinical trial  Not indicated

Neoadjuvant: Drugs/Dosage:

\_\_\_\_\_

Adjuvant: Drugs/Dosage:

\_\_\_\_\_

I.V. Port Inserted, Date: \_\_\_/\_\_\_/\_\_\_\_  I.V. Port Removed, Date: \_\_\_/\_\_\_/\_\_\_\_

Endocrine therapy If yes, medication(s):

Tamoxifen Recommended length of time/dosage: \_\_\_\_\_

Aromatase Inhibitor Recommended length of time/dosage: \_\_\_\_\_

Other: \_\_\_\_\_ Recommended length of time//dosage: \_\_\_\_\_

**Post-Treatment Precautions:**  No  Yes If yes, \_\_\_\_\_

\_\_\_\_\_

**Post-Treatment Contraindications:**  No  Yes If yes, \_\_\_\_\_

**Side Effects:**

Were any of the following side effects experienced?

Hair loss  Nausea/Vomiting  Fatigue  Low blood count  Neuropathy

Menopause symptoms  Cardiac symptoms  Lymphodema

## Radiation Therapy

**Consult date:** \_\_\_/\_\_\_/\_\_\_

**Date Started:** \_\_\_/\_\_\_/\_\_\_ **Date Completed:** \_\_\_/\_\_\_/\_\_\_  Patient Declined

Number of Treatments: \_\_\_\_\_ Total Radiation Dose: \_\_\_\_\_

**Radiation Type:**  Whole breast radiation  Partial breast radiation  Axillary radiation  
 Canadian regimen  Other: \_\_\_\_\_  Not indicated

**Post-Treatment Precautions:**  No  Yes If yes, \_\_\_\_\_

**Post-Treatment Contraindications:**  No  Yes If yes, \_\_\_\_\_

### Side Effects:

Were any of the following side effects experienced?

- Hair loss  Nausea/Vomiting  Fatigue  Low blood count  Neuropathy  
 Menopause symptoms  Cardiac symptoms  Lymphedema  
 Other \_\_\_\_\_

## Supportive Services

**Visiting Nurse, Referral:**  No  Yes

If yes, why: \_\_\_\_\_ Name of provider: \_\_\_\_\_

**Physical Therapist/Lymphedema, Referral:**  No  Yes

If yes, why: \_\_\_\_\_ Name of provider: \_\_\_\_\_

**Nutritionist, Referral:**  No  Yes

If yes, why: \_\_\_\_\_ Name of provider: \_\_\_\_\_

**Counseling Services, Referral:**  No  Yes

If yes, why: \_\_\_\_\_ Name of provider: \_\_\_\_\_

**Post surgical Prosthetics, Referral:**  No  Yes

If yes, why: \_\_\_\_\_ Name of provider: \_\_\_\_\_

**Acupuncture/Massage Therapy, Referral:**  No  Yes

If yes, why: \_\_\_\_\_ Name of provider: \_\_\_\_\_

## Recommended Surveillance Schedule

Physician Follow-Up Appointments	Year One: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other: _____ Year Two: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other: _____ Year Three: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other: _____ Year Four: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other: _____ Year Five: <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other: _____
Breast Exam	<input type="checkbox"/> Clinical Breast Exam <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Breast Self-Exam <input type="checkbox"/> Monthly <input type="checkbox"/> Other: _____
<input type="checkbox"/> Mammogram <input type="checkbox"/> MRI	<input type="checkbox"/> 6 months <input type="checkbox"/> 12 months <input type="checkbox"/> Other: _____
Colon Screening >age 50	<input type="checkbox"/> Baseline <input type="checkbox"/> Follow-Up Screening Frequency: _____
Pelvic Exam	<input type="checkbox"/> 12 months <input type="checkbox"/> Other: _____
Osteoporosis Screening	<input type="checkbox"/> Baseline <input type="checkbox"/> Follow-Up Screening Frequency: _____
Other	

Additional Information		
<b>American Cancer Society</b>	1-800-ACS-2345	<a href="http://www.cancer.org">www.cancer.org</a>
<b>Cancer Information Service</b>	1-800-4-CANCER	<a href="http://cis.nci.nih.gov/">http://cis.nci.nih.gov/</a>
<b>National Cancer Institute</b>	1-800-422-6237	<a href="http://www.cancer.gov">www.cancer.gov</a>
<b>American Society of Clinical Oncology</b>	1-888-273-3508	<a href="http://www.cancer.net/patient/Survivorship">www.cancer.net/patient/Survivorship</a>

- This Survivorship Care Plan is a cancer treatment summary and follow-up plan and is provided to you to keep with your health care records and to share with your primary care provider or any of your doctors and nurses.
- This summary is a brief record of major aspects of your cancer treatment, not a detailed or comprehensive record of your care. You should review this with your cancer provider.