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: □ 3 months □ 6 months □ Other: _____ Year Two: □ 3 months □ 6 months □ Other: _____ Year Three: □ 3 months □ 6 months □ Other: _____ Year Four: □ 3 months □ 6 months □ Other: _____ Year Five: □ 6 months □ 12 months □ Other: _____
Breast Exam	□ Clinical Breast Exam □ 6 months □ 12 months □ Breast Self-Exam □ Monthly □ Other: _____
□ Mammogram □ MRI	□ 6 months □ 12 months □ Other: _____
Colon Screening >age 50	□ Baseline □ Follow-Up Screening Frequency: _____
Pelvic Exam	□ 12 months □ Other: _____
Osteoporosis Screening	□ Baseline □ Follow-Up Screening Frequency: _____
Other	

Additional Information

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

- 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.