

ASCO Treatment Summary and Survivorship Care Plan for Non-Small Cell Lung Cancer

General Information

Patient Name:	Patient DOB:
Patient phone:	Email:
Health Care Providers (Including Names, Institution)	
Primary Care Provider:	
Surgeon:	
Radiation Oncologist:	
Medical Oncologist:	
Other Providers:	

Treatment Summary

Diagnosis

Cancer Type/Location/Histology Subtype: Non-Small Cell Lung Cancer	Diagnosis Date (year):
Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> Not applicable	

Treatment Completed

Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery Date(s) (year):	
Surgical procedure/location/findings:		
Radiation <input type="checkbox"/> Yes <input type="checkbox"/> No	Body area treated:	End Date (year):
Systemic Therapy (chemotherapy, hormonal therapy, other) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Names of Agents Used		End Dates (year)
<input type="checkbox"/> Carboplatin		
<input type="checkbox"/> Cisplatin		
<input type="checkbox"/> Gemcitabine		
<input type="checkbox"/> Paclitaxel/Docetaxel		
<input type="checkbox"/> Pemetrexed		
<input type="checkbox"/> Vinorelbine		
<input type="checkbox"/> Other		
Persistent symptoms or side effects at completion of treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (enter type(s)) :		

Treatment Ongoing

Need for ongoing (adjuvant) treatment for cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional treatment name	Planned duration	Possible Side effects

Follow-up Care Plan

Schedule of Clinical Visits

Coordinating Provider	When/How often

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Cancer Surveillance or Other Recommended Tests																	
Coordinating Provider	Test	How Often															
<p>Please continue to see your primary care provider for all general health care recommended for a (man) (woman) your age, including cancer screening tests. Any symptoms should be brought to the attention of your provider:</p> <ol style="list-style-type: none"> 1. Anything that represents a brand new symptom; 2. Anything that represents a persistent symptom; 3. Anything you are worried about that might be related to the cancer coming back. 																	
<p>Possible late- and long-term effects that someone with this type of cancer and treatment may experience:</p> <ul style="list-style-type: none"> • Constipation • Esophageal stricture • Hearing loss • Kidney problems • Peripheral neuropathy or numbness and tingling • Pneumonitis or inflammation of the lung (3-6 months after treatment) • Pulmonary fibrosis or scarring • Trouble with or painful swallowing 																	
<p>Cancer survivors may experience issues with the areas listed below. If you have any concerns in these or other areas, please speak with your doctors or nurses to find out how you can get help with them.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Anxiety or depression</td> <td><input type="checkbox"/> Insurance</td> <td><input type="checkbox"/> Sexual Functioning</td> </tr> <tr> <td><input type="checkbox"/> Emotional and mental health</td> <td><input type="checkbox"/> Memory or concentration loss</td> <td><input type="checkbox"/> Stopping Smoking</td> </tr> <tr> <td><input type="checkbox"/> Fatigue</td> <td><input type="checkbox"/> Parenting</td> <td><input type="checkbox"/> Weight changes</td> </tr> <tr> <td><input type="checkbox"/> Fertility</td> <td><input type="checkbox"/> Physical functioning</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Financial advice or assistance</td> <td><input type="checkbox"/> School/work</td> <td></td> </tr> </table>			<input type="checkbox"/> Anxiety or depression	<input type="checkbox"/> Insurance	<input type="checkbox"/> Sexual Functioning	<input type="checkbox"/> Emotional and mental health	<input type="checkbox"/> Memory or concentration loss	<input type="checkbox"/> Stopping Smoking	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Parenting	<input type="checkbox"/> Weight changes	<input type="checkbox"/> Fertility	<input type="checkbox"/> Physical functioning	<input type="checkbox"/> Other	<input type="checkbox"/> Financial advice or assistance	<input type="checkbox"/> School/work	
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<p>A number of lifestyle/behaviors can affect your ongoing health, including the risk for the cancer coming back or developing another cancer. Discuss these recommendations with your doctor or nurse:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alcohol use</td> <td><input type="checkbox"/> Physical activity</td> <td><input type="checkbox"/> Other</td> </tr> <tr> <td><input type="checkbox"/> Diet</td> <td><input type="checkbox"/> Sun screen use</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Management of my medications</td> <td><input type="checkbox"/> Tobacco use/cessation</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Management of my other illnesses</td> <td><input type="checkbox"/> Weight management (loss/gain)</td> <td></td> </tr> </table>			<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Physical activity	<input type="checkbox"/> Other	<input type="checkbox"/> Diet	<input type="checkbox"/> Sun screen use		<input type="checkbox"/> Management of my medications	<input type="checkbox"/> Tobacco use/cessation		<input type="checkbox"/> Management of my other illnesses	<input type="checkbox"/> Weight management (loss/gain)				
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<p>Resources you may be interested in:</p> <ul style="list-style-type: none"> • www.cancer.net • Other: 																	
<p>Other comments:</p>																	
Prepared by:		Delivered on:															

- 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.