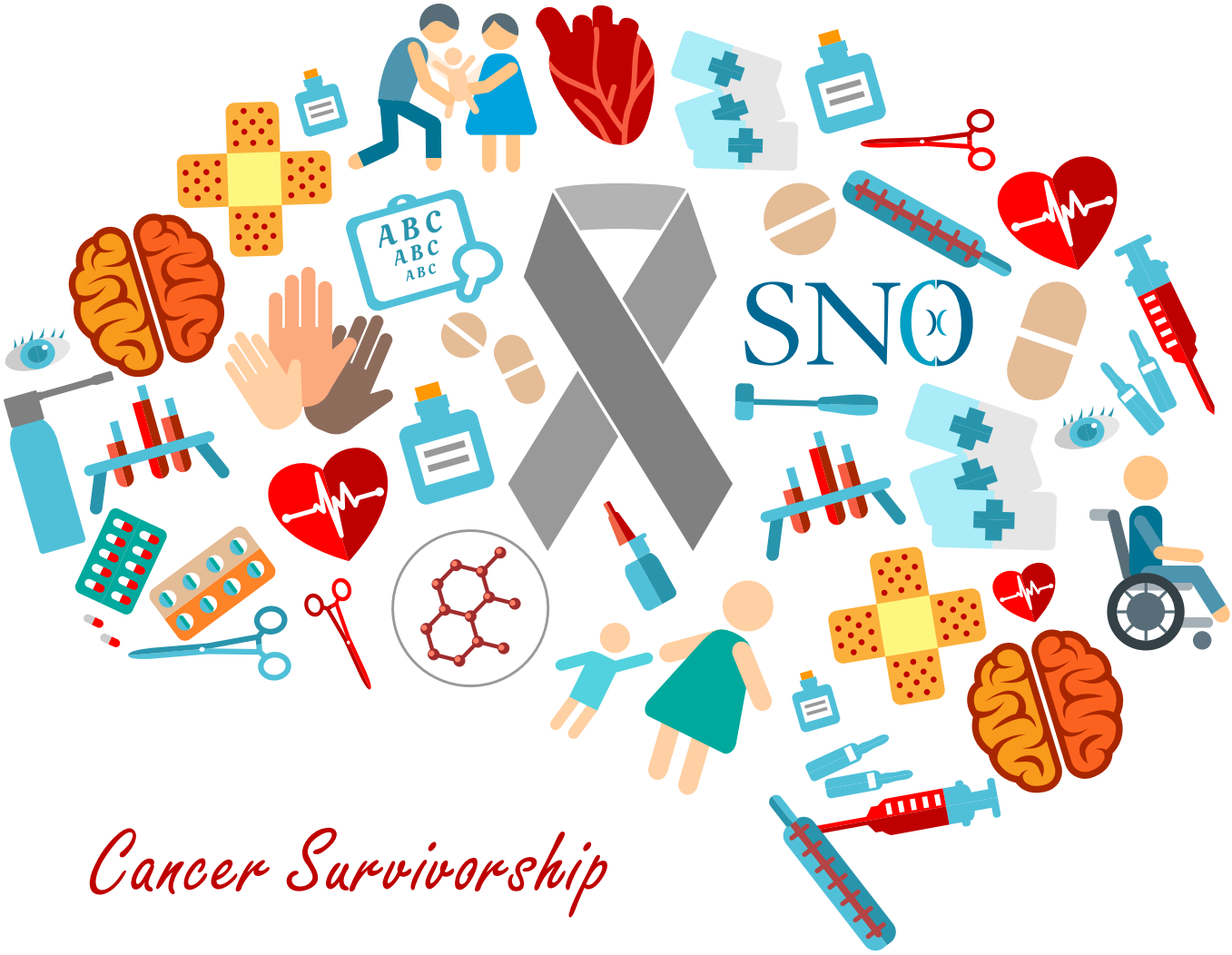
NEURO-ONCOLOGY PATIENT SURVIVORSHIP PLAN



Resources and Tools for the Multidisciplinary Team

Your survivorship care plan is a summary of your tumor treatments and recommendations for follow up care. It also provides you with some information about what to expect and where you can find answers to questions about survivorship. This plan is intended to assist patient and caregivers with many different types of tumors. Any aspects of the plan that do not apply can be left blank.

DIAGNOSIS AND TREATMENT SUMMARY

The diagnosis and treatment summary is a brief record of the major components of your tumor treatment. It includes some information about your diagnosis, any surgery, radiation or chemotherapy you completed and any side effect(s) you may have experienced.

FINAL PATHOLOGY REPORT DIAGNOSIS

Date of Surgery:	WHO grade:
Tumor Type:	
Molecular and/or genetic markers, if applicable:	
Tumor Location:	

TUMOR-DIRECTED THERAPIES

SURGERY

Neurosurgeon and hospital where first surgery performed:

Extent of resection: biopsy/partial removal/complete removal:

Post-operative complications, if any (example: stroke, blood clots):

If applicable, any improvement or worsening of neurologic function (example: ability to speak, walk, use arm and/or leg) after surgery?

Any additional information about surgery?

If more than one surgery:

Date of Surgery:	Neurosurgeon & Hospital:
Tissue Diagnosis:	Biopsy/Partial or Complete Removal:

Any complications?

Any improvement or worsening after surgery?

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Tissue Diagnosis:	Biopsy/Partial or Complete Removal:

Any complications?

Any improvement or worsening after surgery?

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Tissue Diagnosis:	Biopsy/Partial or Complete Removal:

Any complications?

Any improvement or worsening after surgery?

CHEMOTHERAPY

1. Treatment Dates:

Enrolled on trial? If so, please provide study name and number:

Chemotherapy name (+ study drug if applicable):

Any side effects or toxicities?

☐ Hematologic toxicity ☐ Fatigue ☐ Nausea/vomiting ☐ Other: _____

Please indicate if treatment may have been stopped due to toxicity, side effects or progression:

☐ Hematologic toxicity ☐ Side effects ☐ Progression ☐ Other:

2. Treatment Dates:

Enrolled on trial? If so, please provide study name and number:

Chemotherapy name (+ study drug if applicable):

Any side effects or toxicities?

☐ Hematologic toxicity ☐ Fatigue ☐ Nausea/vomiting ☐ Other: _____

Please indicate if treatment may have been stopped due to toxicity, side effects or progression:

☐ Hematologic toxicity ☐ Side effects ☐ Progression ☐ Other:

3. Treatment Dates:

Enrolled on trial? If so, please provide study name and number:

Chemotherapy name (+ study drug if applicable):

Any side effects or toxicities?

☐ Hematologic toxicity ☐ Fatigue ☐ Nausea/vomiting ☐ Other: _____

Please indicate if treatment may have been stopped due to toxicity, side effects or progression:

☐ Hematologic toxicity ☐ Side effects ☐ Progression ☐ Other:

4. Treatment Dates:

Enrolled on trial? If so, please provide study name and number:

Chemotherapy name (+ study drug if applicable):

Any side effects or toxicities?

☐ Hematologic toxicity ☐ Fatigue ☐ Nausea/vomiting ☐ Other: _____

Please indicate if treatment may have been stopped due to toxicity, side effects or progression:

☐ Hematologic toxicity ☐ Side effects ☐ Progression ☐ Other:

5. Treatment Dates:

Enrolled on trial? If so, please provide study name and number:

Chemotherapy name (+ study drug if applicable):

Any side effects or toxicities?

☐ Hematologic toxicity ☐ Fatigue ☐ Nausea/vomiting ☐ Other: _____

Please indicate if treatment may have been stopped due to toxicity, side effects or progression:

☐ Hematologic toxicity ☐ Side effects ☐ Progression ☐ Other: _____

RADIATION

1. Treatment Dates:

If enrolled on a radiation based clinical trial, please provide study name:

Radiation Oncologist & Treatment Center Name:

Type of radiation and dose (for example, IMRT, proton, stereotactic radiosurgery (SRS)):

Radiation Target (brain tumor only, whole brain, brain and spinal cord, spinal cord tumor only):

If any complications during radiation, please describe (examples: increased weakness, confusion, vomiting):

2. Treatment Dates:

If enrolled on a radiation based clinical trial, please provide study name:

Radiation Oncologist & Treatment Center Name:

Type of radiation and dose (for example, IMRT, proton, stereotactic radiosurgery (SRS)):

Radiation Target (brain tumor only, whole brain, brain and spinal cord, spinal cord tumor only):

If any complications during radiation, please describe (examples: increased weakness, confusion, vomiting):

3. Treatment Dates:

If enrolled on a radiation based clinical trial, please provide study name:

Radiation Oncologist & Treatment Center Name:

Type of radiation and dose (for example, IMRT, proton, stereotactic radiosurgery (SRS)):

Radiation Target (brain tumor only, whole brain, brain and spinal cord, spinal cord tumor only):

If any complications during radiation, please describe (examples: increased weakness, confusion, vomiting):

Any hospitalizations during chemotherapy or radiation treatment? If yes, please list where and date(s):

OTHER TREATMENTS (list any other tumor-directed treatments or devices):

SYMPTOM MANAGEMENT MEDICATIONS

(steroids, anti-seizure, sedatives/sleep aids, anti-depressants, anti-nausea, bowel regimen, pain management, etc.):

Drug Name:	Dose and Frequency: (example: 500mg 2x daily)
Start Date:	End Date (if any):
Please describe any side effects and/or reason drug stopped:	

Drug Name:	Dose and Frequency:
Start Date:	End Date (if any):
Please describe any side effects and/or reason drug stopped:	

Drug Name:	Dose and Frequency:
Start Date:	End Date (if any):
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Start Date:	End Date (if any):
Please describe any side effects and/or reason drug stopped:	

FERTILITY PRESERVATION

Please indicate if prior to starting chemotherapy you utilized sperm banking or egg harvesting/banking (circle one) and where you were referred:

HEALTHCARE PROVIDERS INVOLVED IN YOUR CARE

Specialty	Name	Location	Contact Information
Primary Care Provider:			
Oncologist:			
Neurologist:			
Radiation Oncologist:			
Neurosurgeon:			
Physiatrist:			
ENT (otolaryngologist):			
Endocrinologist:			
Any others (such as social worker or nurse navigator):			

Primary caregiver name:

Please list any completed advanced directives:

ANY SUPPORTIVE CARE REFERRALS DURING TREATMENT?

- ☐ Rehabilitation services
- ☐ Physical therapy
- ☐ Occupational therapy
- ☐ Palliative care
- ☐ Speech pathologist
- ☐ Neuropsychologist
- ☐ Psychologist
- ☐ Social work
- ☐ Dietician or nutritionist
- ☐ Survivorship center or patient advocacy organization
- ☐ Complementary and alternative medicine

List any others:

GENETICS

Within the field of cancer as a whole, it is currently thought about 5% of cancer patients have cancer due to a genetic mutation which they inherited. A referral to a genetic counselor for genetic testing of your DNA can be arranged by your healthcare provider based on your unique personal and family medical history. This is independent from any genetic or mutation testing performed on your tumor tissue.

Please indicate if you have had genetic counseling: ☐ Yes ☐ No

Genetic testing results:

Any genetic or hereditary risk factors or predisposing conditions?

YOUR FOLLOW-UP PLAN

With any tumor diagnosis there is a possibility the tumor could return. The chance of this happening and the location of the returning tumor depends on many factors including the grade of the tumor as described in the pathology report. Some tumors return in or near the same place where they were originally found while other tumor types can return at locations distant from their origin. Part of your follow-up care may include specific exams such as MRI, CT or PET scans to monitor your tumor.

NEUROIMAGING

Year 1: Your next MRI scan of your Head/Cervical/Thoracic/Lumbar spine with & without contrast will be on:

_____ and repeated every _____ months.

Year 2: Your next MRI scan of your Head/Cervical/Thoracic/Lumbar spine with & without contrast will be on:

_____ and repeated every _____ months.

Year 3: Your next MRI scan of your Head/Cervical/Thoracic/Lumbar spine with & without contrast will be on:

_____ and repeated every _____ months.

Year 4: Your next MRI scan of your Head/Cervical/Thoracic/Lumbar spine with & without contrast will be on:

_____ and repeated every _____ months.

Year 5: Your next MRI scan of your Head/Cervical/Thoracic/Lumbar spine with & without contrast will be on:

_____ and repeated every _____ months.

Any additional information:

BLOODWORK

Your next blood draw for lab work will be on: _____ at _____ .

Your next blood draw for lab work will be on: _____ at _____ .

Your next blood draw for lab work will be on: _____ at _____ .

Your next blood draw for lab work will be on: _____ at _____ .

Your next blood draw for lab work will be on: _____ at _____ .

Any additional information:

BRAIN RADIATION LONG-TERM MONITORING RECOMMENDATIONS

Depending on your unique radiation treatment plan, there may be potential long-term monitoring recommendations such as endocrine and cognitive function testing, hearing or eye examinations.

Please discuss with your radiation oncologist what your long-term monitoring plan should be:

TREATMENT FOR ONGOING SIDE EFFECTS OF YOUR TUMOR OR ITS TREATMENTS

Many of the side effects from your treatment occur during and a short time after your receive your treatments. Most of these side effects eventually resolve over days or in some cases months after you complete your treatment. Sometimes, there may be long lasting side effects that do not completely resolve and may be related to neurologic changes which may not be reversible. You will be closely monitored for long lasting side effects and neurologic changes. We will discuss additional interventions to optimize your quality of life, symptom management and neurologic function.

List ongoing side effect(s), if stable, improving or worsening, and any ongoing treatments or therapies intended to address your symptom(s) (please describe):

List any side effect(s) that may have resolved (please describe):

Cancer survivors may experience issues with the areas listed below. If you have any concerns in these or other areas, please speak with your healthcare team to find out how you can get help with them.

- ☐ Emotional and mental health
- ☐ School/work
- ☐ Weight changes
- ☐ Financial advice or assistance
- ☐ Fatigue
- ☐ Physical functioning
- ☐ Stopping smoking
- ☐ Fertility
- ☐ Memory or concentration loss
- ☐ Sexual functioning
- ☐ Parenting
- ☐ Insurance/disability
- ☐ Any others:

MONITORING FOR LONG-TERM SIDE EFFECTS OF TUMOR-DIRECTED TREATMENTS

Many tumor treatments have a small risk of causing long-term problems including another type of cancer such as leukemia or changes to other organs like the lungs. Some people may have trouble becoming pregnant or fathering a child, and may be unable to do so. You will be closely followed for possible long-term effects from your tumor treatments. We want you to discuss any changes in your usual state of health with your healthcare team. Many of these problems would be found as part of your routine follow-up and surveillance, but some could require specific testing.

List any known long-term effects that should be monitored based on agents given:

OTHER POSSIBLE LIFE EFFECTS FROM YOUR CANCER DIAGNOSIS

A tumor diagnosis is always life changing. Along with the physical effects of treatment, your diagnosis and your treatment may have other effects, for example:

- It may lead to feelings of depression and/or anxiety.
- It may affect your body image, your physical relationships and your sexual function.
- It may impact your personal relationships or you may feel more stressed at work or with your family and friends.
- It may impact your ability to obtain life insurance and may influence your employment.

But there is help and support available by talking with your healthcare team about your concerns.

YOUR HEALTH MAINTENANCE

With the completion of this treatment, it is a good time to check in with your primary care provider for general health follow up. Health maintenance is very important and maintaining a relationship with your primary care provider is strongly encouraged. If you have not made an appointment with your primary care provider, please do so.

Recommendations from your oncologist:

- ☐ Stop smoking
- ☐ Stress reduction
- ☐ Exercise program
- ☐ Any others:
- ☐ Diet modification
- ☐ Psychosocial support
- ☐ Financial counseling
- ☐ Weight loss
- ☐ Support group
- ☐ Sun protection including sunscreen use

Any additional personal notes:

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