TORRANCE MEMORIAL
A CEDARS-SINAI AFFILIATE

Hunt Cancer Institute

# MY CANCER TREATMENT SUMMARY

Name: _____

Diagnosis:_____

Date of diagnosis: _____ Other: _____

## BIOPSY/SURGERY

| | Date of surgery | Surgical site | Type of surgery | Name/address/phone # of where surgery was performed | Surgeon's name/ address/phone number |
|---|---|---|---|---|---|
| Biopsy | | | | | |
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|---|---|---|---|---|---|
| Primary Surgery | | | | | |
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| | | | | | |
| Other: | | | | | |
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List any major complications from any of the surgeries:_____

_____

_____

_____

_____

**MEDICAL TREATMENTS: Medical Oncology, Radiation Oncology, Other**

| Appointment Date | Name/address/phone # of physician/nurse practitioner | Procedures or tests | Treatment Plan including medications | Other |
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Complications with procedures (if any):

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**MEDICATION RECORD**

| Name | Strength | Amount | Directions | Start date | End date | Ordered by |
|---|---|---|---|---|---|---|
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Describe allergic reactions to any drugs: _____

_____

Hospitalizations for any adverse drug reactions (specify which drug, # of admissions, treatment and outcome): _____

_____

_____

Change in dose or medication due to adverse reactions: _____

_____

_____

We recommend you keep copies of the following records:
Physician dictated history and physicals, discharge summaries and treatment summaries
Dictated operative and procedure reports
Pathology/laboratory reports
Second opinion reports
Reports of any imaging (bone scan, MRI, CT, PET) from before and after surgery
If available, we recommend copies (either films or disks) of all pertinent radiologic examinations such as x-rays, MRI, PET, CT.

## SUGGESTED FOLLOW-UP PLAN OF CARE

Your follow-up plan should be based on the treatment you received as well as current medical science recommendations for your current health needs. Work with your doctors to fill in the information.

Physician Follow-up

| Specialty | Name/Phone number | How often to see | Next appointment |
|---|---|---|---|
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Imaging/Studies/Lab work

| Study Type | Location/Phone number | How often to have | Next appointment |
|---|---|---|---|
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