Patient name: DOB: : (/ /)

☐ This summary is provided to the above named patient for educational purposes. Not meant to replace medical chart.
☐ A copy will also be sent to the primary doctor for coordination of care.

(This form can be filled on a computer and printed. Click ( ) for drop down menus with choices. Click ☐ to check or uncheck. will allow you to type in or type over. Use tab to move to the next section faster. Will work best in Word 2007 or higher. You can save it in Word or in PDF. Then print as needed).

Primary oncologist	
Oncology care team	Hope Cancer Clinic
Medical oncologist	Harmesh R. Naik, MD.
Address	14555 Levan Road, Suite 110, Livonia, MI 48154.
Phone number	734-462-2990
Fax number	734-462-3268
website	hopecancerclinic.net

Diagnosis details		
Diagnosis:	Breast cancer.	Date of diagnosis (biopsy date) : (/ /)
Location	☐ Right ☒ Left. ☐ Bilateral.	
Tumor type	( )	
Stage: ☐ Clinical . ☐ Pathological. ☐ Preliminary. ☐ Pending. ☐ Final. Stage: ☐ 0. ☐ 1. ☐ 2. ☐ 3. ☐ 4. TNM stage: T( ) N ( ) M( ) .		
ER status	☐ Negative. ☐ Positive. ☐ Unknown. ☐ Pending.	
PR status	☐ Negative. ☐ Positive. ☐ Unknown. ☐ Pending.	
Her 2 status	☐ Negative. ☐ Positive. ☐ Unknown. ☐ Pending.	
Lymph nodes	☐ Negative. ☐ Positive. How many: . ☐ Unknown.	

Breast surgery	
☐ Decision Pending. ☐ Planned. ☐ Ongoing. ☐ Completed. ☐ Patient declined. ☐ Not indicated.	
Side: ☐ Right. ☐ Left. ☐ Bilateral.	Intent: ☐ Diagnosis only. ☐ Palliative. ☐ Curative resection.
Type of surgery	( ) (Click here to enter a date.)
	( ) (Click here to enter a date.)
	( ) (Click here to enter a date.)
Lymph node sampling	( ) ( ) (Click here to enter a date.)
Post mastectomy Reconstruction	( ) (Click here to enter a date.)
Lymphedema	☒ Yes. ☐ No. ☐ Unknown.
Additional details: Please contact your surgical doctor for additional details.	
Surgical doctor (Name and phone)	Dr.

Chemotherapy	
☐ Decision Pending. ☐ Planned. ☐ Ongoing. ☐ Completed. ☐ Patient declined. ☐ Not indicated.	
Chemotherapy intent: ☐ Potentially curative, adjuvant or neoadjuvant. ☐ Disease or symptom control.	
Regimen	( )
Details of regimen (Insert name and dose in each box)	
WBC growth factor support ( )	Transfusion support ( )
Hospitalization for toxicity	( )
Anthracycline total dose	( ) (mg/m2)
Early termination	( )
Chemotherapy start date	(Click here to enter a date.)
Chemotherapy completed	(Click here to enter a date.)
ECOG performance status at start of treatment: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4	
Major side effects of this regimen: ☐ Hair loss. ☐ Nausea/Vomiting. ☐ Neuropathy. ☐ Low blood count ☐ Fatigue. ☐ Menopause symptoms. ☐ Cardiac. ☐ Other	
Reason for stopping treatment: ☐ Completion . ☐ Toxicity. ☐ Progression. ☐ Other .	
Response to treatment: ☐ Complete. ☐ Partial. ☐ No response/stable. ☐ Progression. ☐ Not measurable.	
Additional details / complications / comments:	

Trastuzumab (Herceptin) therapy	
☐ Decision Pending. ☐ Planned. ☐ Ongoing. ☐ Completed. ☐ Patient declined. ☐ Not indicated.	
☐ Herceptin	Start : . Stop date: .
Details :	

Hormonal therapy		
☐ Decision Pending. ☐ Planned. ☐ Ongoing. ☐ Completed. ☐ Patient declined. ☐ Not indicated.		
☐ Tamoxifen	Start : (/ /) .	Stop date: (/ /) .
☐ Arimidex (Anastrozole).	Start : (/ /) .	Stop date: (/ /) .
☐ Femara (Letrozole).	Start : (/ /).	Stop date: (/ /) .
☐ Aromasin (Exemestane).	Start : (/ /).	Stop date: (/ /) .
Additional details:		

Radiation therapy	
☐ Decision Pending. ☐ Planned. ☐ Ongoing. ☐ Completed. ☐ Patient declined. ☐ Not indicated.	
Side	☐ Right ☐ Left. ☐ Bilateral.
Radiation completed	( ) (Click here to enter a date.)
Radiation dose	rads
Radiation doctor (Name and phone)	( ) Dr.
Additional details: Please contact your radiation doctor for additional details.	

Referrals recommended / provided:	
Check on box: ☐ Dietician ☐ Smoking cessation counselor ☐ Physical therapist or exercise specialist ☐ Genetic counselor	☐ Psychiatrist ☐ Psychologist ☐ Social worker ☐ Fertility specialist or endocrinologist ☐ Other:

What to watch for: Promptly report any new symptoms: Example symptoms:	
• New lumps • Bone pain • Chest pain, breathing difficult, cough • Abdominal pain	• Persistent headaches • Weight loss, loss of appetite • Any other symptoms that are not improving • Unexplained symptoms

Survivorship care: Suggested follow up care for asymptomatic patients: Based on ASCO guidelines			
☑	Medical history/physical exam	Every 4 months x 3 years Every 4-6 months years 4-5 Annually thereafter	
☑	Breast self exam	Monthly if feasible	
☑	Mammography	Annually or earlier if suggested by radiologist (first in six months after RT)	
☑	Genetic counseling	Consider if criteria met (see below)	
☑	Colo-rectal cancer screening	Recommended.	
☑	Pap smear and pelvic exam	Recommended.	Contact primary MD or Gyn MD.
☑	Skin cancer screening	Recommended	Use sun block in summer.
☑	No smoking /smoking cessation	Recommended- Do not smoke	Michigan Tobacco Quit Line: 1-800-784-8669
☑	Bone density measurement	Recommended.	Contact primary MD.
☑	Oral calcium and vitamin D intake	Recommended	
☑	Low fat diet	Recommended	Consider nutritional consult
☑	General exercise -staying active	Recommended	
☑	Fall precautions	Recommended	
☑	Report any new symptoms	Recommended	

REMEMBER:
Please note that the ASCO guidelines apply to patient who are feeling fine and have no symptoms.
If you are having any symptoms, then you need to contact your physician for proper testing.

GENETIC RISK ASSESSMENT FOR HEREDITARY BREAST AND OVARIAN CANCER

Who should be tested for Hereditary Breast and Ovarian Gene mutations (BRCA 1 and BRCA 2):

Check applicable		**Referral for genetic counseling: Criteria include:**	**Details on relative (e.g. mother, sister.)**
Yes	**No**		
		Based on the American Society of Clinical Oncology (ASCO) – 2006 criteria:	
☐.	☐.	Ashkenazi Jewish heritage.	--
☐.	☐.	History of ovarian cancer at any age in the patient or any first- or second-degree relatives.	
☐.	☐.	Any first degree relative with a history of breast cancer diagnosed before age 50 years.	
☐.	☐.	Two or more first- or second-degree relatives diagnosed with breast cancer at any age.	
☐.	☐.	Patient or relative with diagnosis of bilateral breast cancer.	
☐.	☐.	History of breast cancer in a male relative.	
		Additional criteria to consider:	
☐.	☐.	A personal history of breast cancer at age 50 or younger	
☐.	☐.	A personal history of triple negative breast cancer	
☐.	☐.	A family history of both breast and ovarian cancers on the same side of the family (either mother's or father's side of the family)	
Please talk to your physician if answer to any of above is yes. Genetic testing is a complicated decision that is best made after detailed consultation with your physician and discussion of risks and benefits of such testing. You may need to check with your insurance regarding coverage for genetic testing.			

This template created by: Harmesh Naik, MD. 2012

Survivors: Most important part of life:

☑	**Have fun! Enjoy life!**	**Highly Recommended**	Click on **http://hopecancerclinic.net/inspirational/fly_a_kite**

Notes: