



**LIVESTRONG™**

RESOURCE FOR CANCER SURVIVORS  
LANCE ARMSTRONG FOUNDATION

# CANCER SURVIVOR'S MEDICAL TREATMENT SUMMARY

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# A CANCER SURVIVOR'S GUIDE TO MAINTAINING YOUR MEDICAL HISTORY AFTER TREATMENT

Once treatment for cancer is completed, most people have occasional checkups with their oncologist, but their primary care physician will provide most of their medical care. Many of these primary care physicians have excellent skills for common illnesses, but some may have little training or experience in dealing with problems related to cancer treatment. The huge number of new treatments for cancer has helped to cure many people, providing them a chance to live longer, stronger and healthier lives. Some cancers that were once life-threatening are now managed as long-term illnesses. However, these powerful treatments may cause problems months or years after the person leaves the care of his or her oncologist.

To remain as healthy as possible, cancer survivors need to maintain detailed medical treatment records. This allows you to share the details of your personal medical history with all of the health care providers you see after your cancer treatment has ended. Keeping records of all of your treatments is good preventive medicine.

Ask your oncologist for a one-page summary explaining your diagnosis and the treatments that you have received. A treatment summary and a list of necessary follow-up tests can help you prevent some late effects of treatment and identify and treat any that do arise. When you know what late effects of treatment to look for, you can avoid worrying about late effects that are unlikely to develop. This summary can be helpful in explaining your personal situation when you visit new physicians or other health care professionals.

## **How to use the treatment record**

The Live Strong treatment record has several sections: surgery, chemotherapy, radiation, stem cell or bone marrow transplant, transfusions and follow-up schedules. Each page is in pdf format (can be viewed with Adobe Acrobat), so it will print out nicely on an 8 1/2 x 11 sheet of paper. You can save these pages on your computer to update and print out as information changes. You can fill in the parts you know (name, addresses of treatment institutions, etc.) and then print the document. If you have had more surgeries for cancer than fit on the first surgery page, print out a second surgery page. Similarly, if you received more chemotherapy drugs than are listed on the chemo page, simply print out another one.

Once you have filled in the parts you can, give the document to your nurse or doctor where you received treatment. They can complete the rest of the form. For instance, your oncologist or nurse practitioner can fill out the portions on chemotherapy medications you received. Your radiation oncologist or nurse practitioner can fill out the sections on radiation. Let your health care team know you would like this document returned to you in a timely manner. You may need to call to remind them about it. Once you get the document back, make a couple of copies. One copy should go to your primary care provider (family doctor, internist or general practitioner) and one should be stored in a safe place.

## Why get copies of important records?

Several sections of the treatment record suggest that you obtain copies of test results such as pathology reports or MRI reports. There are many reasons why it is a good idea to have your own copies of important records:

- You can read the reports at your leisure
- It may give you a feeling of control over aspects of your survivorship
- Records provide you with important information to share with other doctors
- Accurate records help if you need a second opinion
- Sometimes records are lost or put in storage at hospitals, making it difficult or impossible to find them later
- If late effects of treatment develop, the records of your treatment will help your health care providers create the best approach for your care

## How to get copies of records

Not all states have laws that allow people the right to see their own medical records. Even though your signature is required to release your confidential records to insurance companies, it is sometimes difficult to get copies for your own files. Also, some hospitals charge a per-page fee to copy your records for you. To learn about local laws, call the Health Privacy Project at (202) 687-0880, or visit their website at [www.healthprivacy.org](http://www.healthprivacy.org) and click on "State Law."

The easiest way to get records is to request a copy from your doctor when discussing results of tests. Some doctors or nurses will make you a copy at the office to take home with you. You can also ask for a copy of your MRI, CT, PET and x-ray at the time they are taken. You will probably be asked to sign a "Release of Medical Records" form.

If you are trying to get records from treatments given in the past, you can call the medical records department of the treating institution and request that they send you a "Release of Medical Records" form. Many departments will no longer fax this form; they only send it by mail. When you receive it, you can specify in detail which records you would like, and send it back. Keep track of the dates, times and people with whom you spoke. It often requires several calls to get records, and talking with the same person might help. Persist until you get your records. If you encounter problems obtaining records, ask to speak to the medical records librarian. Librarians can be helpful in searching for your records more quickly.

If searching for records makes you uncomfortable, you could ask a family member or friend to help you. Although your signature is necessary, they could do some of the footwork for you. Once you have your records, the hard part is done. Just keep them in a safe place all together in one binder. By storing everything in one place, it makes it easier to share your records with health care providers as necessary.

# **CANCER SURVIVOR'S MEDICAL TREATMENT SUMMARY**

This form provides you with a medical summary of your treatments for cancer and recommendations for health monitoring to help you stay healthy.

**Name when treated:** \_\_\_\_\_

**Name now (if different):** \_\_\_\_\_

**Name of the cancer that you had:** \_\_\_\_\_

**Date of diagnosis:** \_\_\_\_\_

**Date of relapses (if any):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

## SURGERY

Date of surgery: \_\_\_\_\_

Type of surgery: \_\_\_\_\_

Name and address of institution  
where you had surgery: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone number of institution: \_\_\_\_\_

Medical record number: \_\_\_\_\_

Surgeon's name: \_\_\_\_\_

Surgeon's telephone number: \_\_\_\_\_

Nurse practitioner's name: \_\_\_\_\_

Any major complications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Suggested records to get:**
- Copy of discharge summary after surgery
  - Copies of all pathology reports
  - Copies of any second opinions
  - Copies of all imaging (MRI, CT) reports from before and after surgery
  - Copies of pertinent films (x-rays, MRI, CT)

If you have had more than one surgery for cancer, print out this page again and have your surgeon or nurse fill in a separate page for each subsequent surgery.

Name: \_\_\_\_\_

# CHEMOTHERAPY

(continued)

Name and address of institution where  
chemotherapy was given:

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Telephone number of institution:

---

Medical record number:

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Oncologist's name:

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Oncologist's telephone number:

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Nurse or nurse practitioner's name:

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Type of central line (if any):

---

Complications with central line (if any):

---

Name of treatment protocol  
or clinical trial:

---

1. Name of medication:

---

Dose per administration:

---

Number of doses:

---

Cumulative dose:

---

How given (pills, IV through a peripheral vein, IV  
through a central line, intrathecal, etc):

---

Name: \_\_\_\_\_

# CHEMOTHERAPY

(continued)

2. Name of medication: \_\_\_\_\_

Dose per administration: \_\_\_\_\_

Number of doses: \_\_\_\_\_

Cumulative dose: \_\_\_\_\_

How given: \_\_\_\_\_

3. Name of medication: \_\_\_\_\_

Dose per administration: \_\_\_\_\_

Number of doses: \_\_\_\_\_

Cumulative dose: \_\_\_\_\_

How given: \_\_\_\_\_

4. Name of medication: \_\_\_\_\_

Dose per administration: \_\_\_\_\_

Number of doses: \_\_\_\_\_

Cumulative dose: \_\_\_\_\_

How given: \_\_\_\_\_

Name: \_\_\_\_\_

# CHEMOTHERAPY

(continued)

5. Name of medication: \_\_\_\_\_

Dose per administration: \_\_\_\_\_

Number of doses: \_\_\_\_\_

Cumulative dose: \_\_\_\_\_

How given: \_\_\_\_\_

6. Name of medication: \_\_\_\_\_

Dose per administration: \_\_\_\_\_

Number of doses: \_\_\_\_\_

Cumulative dose: \_\_\_\_\_

How given: \_\_\_\_\_

7. Name of medication: \_\_\_\_\_

Dose per administration: \_\_\_\_\_

Number of doses: \_\_\_\_\_

Cumulative dose: \_\_\_\_\_

How given: \_\_\_\_\_

Name: \_\_\_\_\_

# CHEMOTHERAPY

(continued)

**8. Name of medication:** \_\_\_\_\_

**Dose per administration:** \_\_\_\_\_

**Number of doses:** \_\_\_\_\_

**Cumulative dose:** \_\_\_\_\_

**How given:** \_\_\_\_\_

**Anti-nausea medications used:** \_\_\_\_\_

**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:** \_\_\_\_\_

If you received more than eight chemotherapy medications, print out these pages again and have your health care provider fill in the information.

Name: \_\_\_\_\_

# RADIATION

Name and address of institution  
where radiation was given:

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Telephone number of institution:

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Medical record number:

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Name of physician who supervised radiation  
therapy:

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Physician's telephone number:

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Nurse or nurse practitioner's name:

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1. Dates radiation given:

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Type of machine or technology used:  
(e.g., linear accelerator, radioactive  
seeds, radiation ablation, etc)

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---

---

Area treated  
(include any areas shielded):

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---

Amount per session:

---

Total dose of radiation:

---

Name: \_\_\_\_\_

# RADIATION

(continued)

2. Dates radiation given: \_\_\_\_\_

Type of machine used: \_\_\_\_\_

Area treated  
(include any areas shielded): \_\_\_\_\_

Amount per session: \_\_\_\_\_

Total dose of radiation: \_\_\_\_\_

3. Dates radiation given: \_\_\_\_\_

Type of machine used: \_\_\_\_\_

Area treated  
(include any areas shielded): \_\_\_\_\_

Amount per session: \_\_\_\_\_

Total dose of radiation: \_\_\_\_\_

Name: \_\_\_\_\_

## **RADIATION**

(continued)

**4. Dates radiation given:** \_\_\_\_\_

**Type of machine used:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Area treated  
(include any areas shielded):** \_\_\_\_\_

\_\_\_\_\_

**Amount per session:** \_\_\_\_\_

**Total dose of radiation:** \_\_\_\_\_

**Any major complications  
from therapy:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- Suggested records to get:**
- Copies of all radiation reports
  - Copies of any second opinions
  - Copies of all imaging (MRI, CT) reports from before and after radiation
  - Copies of pertinent films (x-rays, MRI, CT)

Name: \_\_\_\_\_

## **STEM CELL or BONE MARROW TRANSPLANT**

Date(s) of transplant: \_\_\_\_\_

\_\_\_\_\_

Type(s) of transplant: \_\_\_\_\_

\_\_\_\_\_

Name and address of institution  
where transplant was performed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone number of institution: \_\_\_\_\_

Medical record number: \_\_\_\_\_

Name of physician who  
supervised transplant: \_\_\_\_\_

Physician's telephone number: \_\_\_\_\_

Nurse or nurse practitioner's name: \_\_\_\_\_

Any major complications  
from transplant: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

# STEM CELL or BONE MARROW TRANSPLANT

(continued)

## Chemotherapy prior to transplant

1. Medication name: \_\_\_\_\_

Total dose: \_\_\_\_\_

How given (pill, peripheral IV, central line, intrathecal, etc.): \_\_\_\_\_

2. Medication name: \_\_\_\_\_

Total dose: \_\_\_\_\_

How given: \_\_\_\_\_

3. Medication name: \_\_\_\_\_

Total dose: \_\_\_\_\_

How given: \_\_\_\_\_

4. Medication name: \_\_\_\_\_

Total dose: \_\_\_\_\_

How given: \_\_\_\_\_

5. Medication name: \_\_\_\_\_

Total dose: \_\_\_\_\_

How given: \_\_\_\_\_

Name: \_\_\_\_\_

# STEM CELL or BONE MARROW TRANSPLANT

(continued)

## Radiation prior to transplant

Date(s) of radiation: \_\_\_\_\_

Area treated with radiation: \_\_\_\_\_

Dose per session: \_\_\_\_\_

Total dose: \_\_\_\_\_

Source of stem cells or bone marrow: \_\_\_\_\_

\_\_\_\_\_

Other pertinent treatment information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

## BLOOD PRODUCT TRANSFUSIONS

Number, types, and dates of transfusions:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Date and results of Hepatitis C testing  
(necessary if transfused  
before July 1992):

\_\_\_\_\_  
\_\_\_\_\_

Date and results of HIV testing:

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

## SUGGESTED FOLLOW-UP

The following suggestions are based on the treatment you received. Ask your doctors to fill in this section.

### Surgical follow-up appointments

**Name of health care provider:**

Example: Surgeon

**Purpose:**

Post-op visit

**Frequency:**

Two weeks after surgery

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### Surgical follow-up tests

**Type of test:**

Example: MRI

**Purpose:**

Check for tumor re-growth

**Frequency:**

Every six months

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Name of health care provider:**

Example: Oncologist

**Purpose:**

Physical examination

**Frequency:**

Every three months

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Name: \_\_\_\_\_

## SUGGESTED FOLLOW-UP

(continued)

### Oncology follow-up tests

Type of test:

Example: Echocardiogram

Purpose:

Check heart function

Frequency:

Every two years

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

### Radiation follow-up tests

Type of test:

Example: X-ray

Purpose:

Check radiation field

Frequency:

Yearly

|       |       |       |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Name: \_\_\_\_\_

## **SUGGESTED FOLLOW-UP**

(continued)

This summary of your treatment and follow-up needs was prepared by:

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After your health care providers have filled out this document, keep one copy for your records and give copies to your current doctors and nurse practitioners. Knowing the details of your treatment will help them provide you with better medical care.