[ ]

The Treatment Plan and Summary provide a brief record of major aspects of limited stage small cell lung cancer treatment. This is not a complete patient history or comprehensive record of intended therapies.

Patient name:	**Patient ID**:
Medical oncology provider name:	
Patient DOB: (/ /)	**Patient phone**:
Support contact name:	
Support contact relationship:	**Support contact phone**:

BACKGROUND AND STAGING INFORMATION

Diagnosis: ☐ Histology ☐ Cytology ☐ Surgical staging

Tobacco use: ☐ No ☐ Yes, past ☐ Yes, current
If current, cessation counseling provided?: ☐ Yes ☐ No ☐ Patient unwilling

Major comorbidities:

Cancer-related symptoms:

Work up: ☐ Bronchoscopy ☐ FNA

Bone Scan : ☐ Yes ☐ No	**CT abdomen:** ☐ Yes ☐ No	**CT brain:** ☐ Yes ☐ No
MRI brain: ☐ Yes ☐ No	**PET scan:** ☐ Yes ☐ No	**PFT's baseline:**

Metastatic sites: ☐ None ☐ Suspicious

Final pathologic details:

TREATMENT PLAN

TREATMENT SUMMARY

White sections to be completed prior to chemotherapy administration, shaded sections following chemotherapy

Height: in/cm	**Pre-treatment weight:** lb/kg	**Post-treatment weight:** lb/kg
Pre-treatment BSA:	**Treatment on clinical trial:** ☐ Yes ☐ No	
Name of chemotherapy regimen:		
Number of cycles planned:		**Number of cycles completed:**
Chemotherapy start date: (/ /)		**Chemotherapy end date:** (/ /)
ECOG performance status at start of treatment: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4		**ECOG performance status at end of treatment:** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4

Chemotherapy Drug Name	Route	Dose mg/m^2	Schedule	Dose reduction	# doses administered
				☐ Yes % ☐ No	
				☐ Yes % ☐ No	
				☐ Yes % ☐ No	
				☐ Yes % ☐ No	

Major side effects of this regimen: ☐ Dysphagia ☐ Esophagitis ☐ Weight loss ☐ RBC transfusion ☐ Hair loss ☐ Nausea/Vomiting ☐ Neuropathy ☐ Low blood count ☐ Fatigue ☐ Menopause symptoms ☐ Cardiac ☐ Dementia ☐ Diabetes ☐ Other

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TREATMENT PLAN (CONTINUED)			TREATMENT SUMMARY (CONTINUED)
Other Therapies	**Route/ Fraction/ Dose/ Dates**	**Purpose/Goal**	**Comments**
Alternative and complementary therapy			
Cancer rehab services			
Primary and Prophylactic Radiation Therapy			

TREATMENT SUMMARY (CONTINUED)

Reason for stopping treatment: ☐ Completion ☐ Toxicity ☐ Progression ☐ Other:

Best Response:

Treatment-related hospitalization required: ☐ Yes ☐ No	**Grade 3/4 toxicities during treatment (list all):**

Persistant toxicity at completion of treatment:
☐ Yes (enter type(s) and grade(s)
☐ No

ADDITIONAL THERAPIES

Therapy	Comments	Date started (or to start)
Esohpagoscopy		**(/ /)**
PEG feeding tube		**(/ /)**
		(/ /)

ONCOLOGY TEAM MEMBER CONTACTS	SURVIVORSHIP CARE PROVIDER CONTACTS
Provider: Medical Oncologist	**Provider:**
Name:	Name:
Oncology Nurse	Contact Info:
Name:	
Contact Info:	**Provider:**
	Name:
Provider: Pulmonologist	Contact Info:
Name:	
Contact Info:	**Provider:**
	Name:
Provider: Radiation Oncologist	Contact Info:
Name:	
Contact Info:	**Provider:**
	Name:
Provider: Thoracic Surgeon	Contact Info:
Name:	
Contact Info:	**Provider:**
	Name:
	Contact Info:

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FOLLOW-UP AND SURVIVORSHIP CARE		
Provider with primary responsibility for follow up care:		
Follow up care	**When/How Often?**	**Coordinating Provider**
Medical oncology visits		
Palliative Care		
Hospice Care		
Imaging – Chest CT w/contrast		
Brain CT or MRI		
Other		
Other		
•		
•		
•		

Potential late effects of treatment(s):

Call your doctor if you have any of these signs and symptoms:

New or recurrent pain
Loss of appetite with weight loss
Worsening cough, shortness of breath
Coughing up blood
Headache
Other:

Needs or concerns:	**Referrals provided:**
☐ Smoking cessation: ☐ Prevention and wellness: ☐ Emotional or mental health: ☐ Personal relationships: ☐ Fertility: ☐ Financial advice or assistance: ☐ Other:	☐ Pulmonary rehabilitation ☐ Smoking cessation counselor ☐ Physical therapist or exercise specialist ☐ Dietician ☐ Psychiatrist ☐ Psychologist ☐ Social worker ☐ Other:

Comments: