

Treatment Summary and Survivorship Care Plan for Prostate Cancer

General Information		
Patient Name:	Patient DOB:	
Patient phone:	Email:	
Health Care Providers (Including Names, Institution)		
Primary Care Provider:		
Urologic Surgeon:		
Radiation Oncologist:		
Medical Oncologist:		
Other Providers:		
Treatment Summary		
Diagnosis		
Cancer Type/Location/Histology Subtype: Prostate Cancer		Diagnosis Date (year):
Stage: <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Not applicable		
Gleason Score:	PSA at Diagnosis:	
Clinical Trial: <input type="checkbox"/> Yes <input type="checkbox"/> No Name/Number:		
Treatment COMPLETED		
Surgery:		Surgery Date(s) (year):
Surgical procedure/location/findings:		
External beam radiation: <input type="checkbox"/> Yes <input type="checkbox"/> No	Prostate/Seminal Vesical only: <input type="checkbox"/> Yes <input type="checkbox"/> No	End Date (year):
	Whole pelvis: <input type="checkbox"/> Yes <input type="checkbox"/> No	End Date (year):
Brachytherapy to prostate: <input type="checkbox"/> Yes <input type="checkbox"/> No		End Date (year):
Systemic Therapy (chemotherapy, hormonal therapy, other): <input type="checkbox"/> Yes <input type="checkbox"/> No		
Duration:		
Names of Agents Used		End Dates (year) or ongoing
<input type="checkbox"/> Casodex		
<input type="checkbox"/> Lupron (or similar LHRH agonist)		
<input type="checkbox"/> Other		
Persistent symptoms or side effects at completion of treatment: <input type="checkbox"/> No <input type="checkbox"/> Yes (enter type(s)):		
Treatment ONGOING		
Need for ongoing (adjuvant) treatment for cancer <input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional Treatment Name	Planned Duration	Possible Side Effects
Follow-up Care Plan		
Schedule of Clinical Visits		
Coordinating Provider	When/Frequency	

Cancer Surveillance or other Recommended Tests

Coordinating Provider	Test	Frequency
	PSA (Prostate Specific Antigen)	

Please continue to see your primary care provider for all general health care recommended for a man your age, including cancer screening tests. Any symptoms should be brought to the attention of your provider:

1. Anything that represents a brand new symptom;
2. Anything that represents a persistent symptom;
3. Anything you are worried about that might be related to the cancer coming back.

Possible late- and long-term effects that someone with this type of cancer and treatment may experience:

- Decreased sex drive
- Enlarging breast tissue
- Erectile dysfunction
- Fatigue
- Hair loss
- Hot flashes
- Incontinence
- Increased body fat
- Loss of muscle mass
- Metabolic syndrome (increased blood pressure, blood sugar, cholesterol)
- Mood swings
- Osteoporosis
- Painful urination
- Rectal pain
- Shortening of the penis
- Skin irritation or darkening
- Sterility
- Tiredness
- Trouble voiding or passing urine (urinary retention)
- Urinary frequency
- Other:

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

- | | | |
|---------------------------------------------------------|-------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Anxiety or depression | <input type="checkbox"/> Insurance | <input type="checkbox"/> Sexual Functioning |
| <input type="checkbox"/> Emotional and mental health | <input type="checkbox"/> Memory or concentration loss | <input type="checkbox"/> Stopping Smoking |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Parenting | <input type="checkbox"/> Weight changes |
| <input type="checkbox"/> Fertility | <input type="checkbox"/> Physical functioning | <input type="checkbox"/> Other |
| <input type="checkbox"/> Financial advice or assistance | <input type="checkbox"/> School/work | |

A number of lifestyle/behaviors can affect your ongoing health, including the risk for the cancer coming back or developing another cancer. Discuss these recommendations with your doctor or nurse:

- | | | |
|----------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Alcohol use | <input type="checkbox"/> Management of other illnesses | <input type="checkbox"/> Tobacco use/cessation |
| <input type="checkbox"/> Diet | <input type="checkbox"/> Physical activity | <input type="checkbox"/> Weight management (loss/gain) |
| <input type="checkbox"/> Management of medications | <input type="checkbox"/> Sunscreen use | <input type="checkbox"/> Other |

Resources you may be interested in:

- www.cancer.net
- Other:

Other comments:

Prepared by:

Delivered on:

- This Survivorship Care Plan is a cancer treatment summary and follow-up plan and is provided to you to keep with your health care records and to share with your primary care provider or any of your doctors and nurses.
- This summary is a brief record of major aspects of your cancer treatment not a detailed or comprehensive record of your care. You should review this with your cancer provider.