My Treatment Plan

Type of cancer: ______________________________ Stage: ____________

Tests I have had or need: ______________________________

____

Surgery Plan

Name of surgeon: ______________________________

Type of surgery: ______________________________

Date of surgery: ______________________________

Date of follow up: ______________________________

Radiation Therapy Plan

Name of radiation oncologist: ______________________________

Name of nurse: ______________________________

Date of simulation: ______________________________

Date starting radiation therapy: ______________________________

Frequency/length of treatment: ______________________________

Total radiation dose: ______________________________

Weekly physician visit (day/time): ______________________________

Medical Oncology Plan

Name of medical oncologist: ______________________________

Name of advanced practice nurse: ______________________________

Date starting chemotherapy: ______________________________

Chemotherapy schedule: ______________________________

Clinical Trial Plan

Name of trial: ______________________________

Name of clinical research coordinator: ______________________________

Date starting clinical trial: ______________________________

NORRIS COTTON CANCER CENTER | *a component of* DARTMOUTH-HITCHCOCK MEDICAL CENTER