TORRANCE MEMORIAL
CANCER SURVIVORSHIP PROGRAM
A PARTNER WITH THE UCLA-LIVESTRONG™ CENTER OF EXCELLENCE

BREAST CANCER SURVIVORSHIP PROGRAM
TREATMENT SUMMARY

Name: _____

Type of cancer:_____

Date of diagnosis: _____ Stage at diagnosis: _____

ER: _____ PR: _____ Her 2:_____

BIOPSY/SURGERY

	Date of surgery	Surgical site	Type of surgery	Name/address/phone # of where surgery was performed	Surgeon's name/ address/phone number
Biopsy					
Primary Surgery					
Lymph nodes			☐Sentinel		
			☐Axillary dissection		
Other:					

List any major complications from any of the surgeries:_____

_____

_____

We recommend you keep copies of the following records:
Physician dictated history and physicals, discharge summaries and treatment summaries
Dictated operative and procedure reports
Pathology reports
Second opinion reports
Reports of any imaging (mammogram, MRI, CT, PET) from before and after surgery
If available, we recommend copies (either films or disks) of all pertinent radiologic examinations such as x-rays, MRI, PET, CT.

CHEMOTHERAPY

Name, address and telephone number of office or institution where chemotherapy was given:

_____

Medical record number: (if applicable)_____

Oncologist's name/address/phone: _____

_____

Nurse or nurse practitioner's name: _____

Type of central line, if any (such as PICC, Port-a-cath®): _____

Complications with central line (if any): _____

_____

Name of treatment protocol or clinical trial: _____

Name of chemotherapy	Date(s) of administration	Dose per administration	Number of doses	Total dose	How given (pill, IV, peripheral, central line)

Anti-nausea medications used: _____

_____

Describe 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: _____
_____

_____

HORMONE THERAPY:

Name of medication	Dose per administration	Start date	Duration of therapy	How given

We recommend you keep copies of the following records:
Physician dictated history and physicals, discharge summaries and treatment summaries
Chemotherapy record
Second opinion reports

RADIATION THERAPY

Name, address and telephone number of institution or clinic where radiation therapy was given: _____
_____

Medical record number:_____

Name of Radiation Oncologist: _____

Physician's telephone number: _____

Nurse or nurse practitioner's name: _____

Dates of radiation course	Type of machine used	Areas treated	Amount per session	Total dose of radiation

We recommend you keep copies of the following records:
Physician dictated history and physicals, discharge summaries and treatment summaries
Second opinion reports
Reports of any imaging (mammogram, MRI, CT, PET) from before and after radiation

If available, we recommend copies (either films or disks) of all pertinent radiologic examinations such as x-rays, MRI, PET, CT.