LYMPHOMA RESEARCH • FOUNDATION

Lymphoma Care Plan

The Lymphoma Research Foundation is pleased to provide this *Lymphoma Care Plan* as a resource and guide to help patients and their physicians discuss and document the cancer experience. Keeping your information in one location can help you feel more in control during and after treatment. Patients should complete this form with their care team. For additional copies of the *Care Plan*, please visit www.lymphoma.org or contact the LRF Helpline at (800) 500-9976 or helpline@lymphoma.org.

Section 1: General Patient Information

Name: **Date of Birth** (MM/DD/YYYY)**:** **Gender** □ Male □ Female

Patient ID: **Patient's Email:**

Patient Phone (Cell/Home/Other) Primary: (□ Cell □ Home □ Other:_____)
Secondary: (□ Cell □ Home □ Other:_____)

Support Person Name: **Relationship to patient:**

Support Contact Info: □ Cell Phone:
□ Home Phone:
□ Email:

Section 2: The Care Team

	Name	Affiliation/Institution	Contact Information (Phone/Email)
Primary Care Provider			
Hematologist/Oncologist			
Radiation Oncologist			
Surgeon			
Transplant Coordinator			
Other Providers:			
Dermatologist			
Dietitian			
Endocrinologist			
Fertility Specialist			
Nurse/ Nurse Practitioner			
OB-GYN			
Physical Therapist			
Psychologist/ Mental Health Provider			
Social Worker			

Section 3. Treatment Summary

3A. Diagnosis

Diagnosis Date (MM/DD/YYYY):	**Cancer Type:** □ CLL □ HL □ NHL **Cancer Subtype (List):**

Stage/Staging Classification	Ann Arbor: _____ □ New □ Recurrent	Lugano: _____ □ New □ Recurrent	Other: _____ □ New □ Recurrent

Diagnosis Confirmed By:	Study	Date (MM/DD/YY)	Study Type	Findings
Biopsy				
Blood Test				
Genetic Test				
Scan				

Patient Pretreatment	Weight:	Height:	Blood Type:

3B. Treatments

Chemotherapy/Other Systemic Therapies □ Yes □ No

Regimen/Agents	Initiation/End Dates	Dose/Admin.Route	Schedule/Cycles	Dose Reduction	Comments
1.					
2.					
3.					
4.					

Radiation □ Yes □ No

Type	Initiation/End Dates	Body Area Treated	Dose	Comments
1.				
2.				

Stem Cell Transplant □ Yes □ No □ Inpatient* □ Outpatient *Admission Date:_____ *Discharge Date:_____	**Type:** □ Allogeneic □ Autologous *Donor Relationship and Information:*

Conditioning Treatment	Conditioning Treatment Date	Transplant Date	Engraftment/Reactions/Comments

Surgery □ Yes □ No

Procedure	Surgery Date	Location	Findings/Comments
1.			
2.			

Other Treatments □ Yes □ No

Procedure	Date	Location	Findings/Comments

3C. Treatment Outcomes

Treatment Part of a Clinical Trial □ Yes □ No	**Study Number (NCT#):**
Treatment Goal:	
Response to Treatment:	
Serious Toxicities/Side Effects *During* **Treatment:**	
Ongoing Toxicities/Side Effects *After* **Treatment:**	

Patient Posttreatment	Weight:	Height:	Blood Type:

Section 4. Follow-Up Care

4A. Maintenance/Adjuvant Treatment

Treatment Name:	**Route of Administration:**	**Dose:**
Planned Schedule and Duration:		
Possible Side Effects:		
Results:		

Section 4B. Possible Late Effects and Long-Term Side Effects

List Here:

Section 4C. Follow-Up Visits

	Type of Visit	When/How Often	Person to Contact
Hematologist/Oncologist			
Blood Work/Lab Tests			
Imaging (CT, PET, etc.)			
Primary Care Physician			
Other			

Section 4D. Revaccination Schedule

Patients should follow the recommended revaccination schedule as directed by their physician.

Vaccination	Date to Receive	Vaccination	Date to Receive
□ Hepatitis B (HBV)		□ Measles, mumps, and rubella (MMR)	
□ Haemophilus influenzae type b (Hib) series		□ Tetanus, diphtheria, and acellular pertussis (TDaP)	
□ Influenza		□ Varicella	
□ Meningococcal conjugate		□ Other:	
□ Pneumococcal conjugate series		□ Other:	
□ Polio		□ Other:	

Section 5. Wellness Concerns and Cancer Screening and Prevention

□ Alcohol Use	□ High blood pressure control
□ Bone Health/DEXA Scan	□ Mammography and Pap tests (women only)
□ Cholesterol Management	□ Mental Health
□ Colonoscopy	□ PSA and rectal exam (men only)
□ Diabetic screening/management	□ Sexual Health and Fertility
□ Diet and Nutrition/Weight Management	□ Tobacco Use/Stopping
□ Exercise/physical activity	□ Other:

Section 6. Self-Assessment of Symptoms

Check any symptoms you experience to discuss symptom management and treatment options with a health care provider.

□ Abdominal pain	□ Fever and sweats	□ Numbness/weakness on one side	□ Weight loss or loss of appetite
□ Changes in appetite	□ General weakness	□ Pain or problems with eating	
□ Chest pain	□ Hair loss	□ Pain with urination	**Women Only**
□ Chronic diarrhea	□ Hearing loss	□ Relationship problems	□ Abnormal vaginal bleeding
□ Constipation	□ Heartburn/indigestion	□ Sexual dysfunction/lack of desire	□ Irregular periods
□ Cough or wheezing	□ Hot flashes/night sweats	□ Shortness of breath	□ Vaginal discharge
□ Decreased exercise ability	□ Irregular heartbeat/palpitations	□ Skin changes, rashes, lumps or bumps	□ Vaginal dryness
□ Dental problems	□ Jaundice (yellowing of skin or eyes)	□ Sleep disturbances	□ Painful intercourse
□ Difficulty breathing	□ Joint pain or muscle aches	□ Slurred speech	□ Premature menopause
□ Dizziness	□ Leg pain with exertion	□ Swelling of arm or leg	**Men Only**
□ Dry mouth	□ Memory/concentration issues	□ Swollen lymph nodes	□ Erectile dysfunction
□ Easy bruising or bleeding	□ Negative body image	□ Urinary incontinence (leaking urine)	
□ Fatigue	□ Neuropathy (pins and needles sensation or numbness)	□ Vision problems	
□ Fertility concerns	□ New/changed moles or freckles	□ Weight gain or overweight	