

CARE PLAN

This care plan summarises information about my diagnosis, treatment, actions to resolve any current concerns, follow up plan, symptoms to look out for and steps I need to take to stay healthy.

My Contact Information	
Name:	Telephone Number:
	Mobile Number:
Address	Main Carer:
Age:	Relationship:
GP:	Telephone Number:
NHS Number	
Lead Consultant	Other Consultant:

My Care Planning Session	
Date:	Duration:
Completed by:	Outcome:
Contact number:	

My Cancer History	
Cancer Diagnosis:	Date of diagnosis:
	Tumour staging: Regional lymph nodes:
Brief Treatment Summary: (e.g. surgery, chemotherapy, radiotherapy, hormone treatment)	
Significant events during treatment: (side effects, weight loss/gain)	
Research/clinical trials:	

My Assessment

In your assessment I have identified the following key concerns where further help and support is required or requested.

1.	Action agreed:
2.	Action agreed:
3.	Action agreed:
Summary of goals:	

My follow up plan (example)

Follow up recommendations	Year 1	Year 2	Year 3	Year 4	Year 5
Hospital appointment	Every 6 months	annual	annual	annual	annual
CEA blood test	Every 3 months	Every 6 months	annual	annual	annual
CT scan	annual	annual			annual
Colonoscopy	annual	annual			annual

Test Results Log:

DOD plus	Date	Test	Result
0y/3m	23.10.10	CEA	Xxx ng/ml
0y/6m			
0y/9m			
1y/0m			
etc			

Life Style advice and self management programme	
Smoking cessation	
Diet and weight management	
Physical Activity	
Sunscreen	
Self management programme	
Information prescription	

Possible treatment side effects and what to do about them	
Possible side effects	What to do
1.	1.
2.	2.
3.	3.

Signs and symptoms to look out for and seek advice on	
Sign of symptom if persistent	Best person to contact:
1.	
2.	
3.	
4.	

Key Contacts	
General enquiries e.g. appointments, tests	Team coordinator Telephone number
Medical concerns:	Clinical Nurse specialist:
Out of Hours – for Urgent Medical Concerns	Ward/On call no: Telephone number:
General Practitioner	Telephone:
Useful organisations:	
Internet sites	

Next Steps	
Would you like a copy of this care plan sent to your GP?	Yes/No
Date of next review (if required)	

My Second Care Plan Review

Date:	Duration:
Completed by:	Outcome of this meeting:
Contact number:	
Reason for care plan review:	

My Second Assessment

In your assessment I have identified the following key concerns where further help and support is required or requested.

1.	Action agreed:
2.	Action agreed:
3.	Action agreed:
Summary of goals:	