Treatment Location(s)

	Diagnosis:				
	Type of Treatment(s)	**Date**	**Doctor(s)/Nurse(s)/Social Worker(s)/Medical Professional**	**Contact Information**	**Notes (Side effects, results, issues, etc.)**
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

	Type of Treatment(s)	Date	Doctor(s)/Nurse(s)/Social Worker(s)/Medical Professional	Contact Information	Notes (Side effects, results, issues, etc.)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Treatment Contacts

	Name	Address	Phone Number	Website
Primary Treatment Center				
Secondary Treatment Center				
Hospital				
Family Doctor				
Primary Oncologist				
Radiation Oncologist				
Hematologist				
Primary Nurse				
Radiation Therapist				
Social Worker				
Dietician				
Other				
Other				

Appointments and Questions

	Date	Time	With Whom?	Reason for Appointment	Phone
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Appointments and Questions

Notes/Questions

Test Results

	Date	WBC Count	Hemoglobin	Platelets	Other	Notes
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						

Medicines

	Date	Name	Purpose	Prescribing Doctor	Dose	Schedule (2xs daily, once a day, etc.)	Notes (side effects, special instructions, etc)
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Insurance Information

Plan Name	Group/ID #	Address	Phone	Primary Holder	Date and Time Called

Notes

****Keep copies of your insurance cards with you for your own records as well**

Notes/Thoughts/Issues/Reminders

Notes

Follow ups and Questions

Questions and Issues