Managing Your Cancer Care Records
Hoʻokele i ke Ola
Cancer Patient Navigation Training Program
is supported through a supplemental grant to
ʻImi Hale Native Hawaiian Cancer Network,
a program of Papa Ola Lōkahi
(U01CA114630-S1).
Contents

What to Include in a Patient Record 4
Managing a Cancer Care Record 5
Your Personal Information Form 6
Your Personal Health History Form 7-8
Your Health Team Form 9
Your Medical Team Form 10-11
Your ‘Ohana Team Form 12-13
Health Insurance Information Form 14

Preparing for Appointments 15
Appointment Notes Form 16-17
Hospitalization Information Form 18
Outpatient Procedure Information Form 19
Chemotherapy Schedule Form 20
Radiation Schedule Form 21
Pharmacy Information 22

Keeping Track of Your Medicines 23
Medication Record Form 24-25
Your Legal Documents 26
Your Journal or Diary 27
Getting a Second Opinion 28
Getting Copies of Your Medical Records 29
Your Bills and Payments Log 30-31
Quick Contact List 32
What to Include in a Patient Record

- Personal Information
- Personal Health History
- Your Health Team
  - Medical Team
  - ‘Ohana Team
- Health Insurance Information
- Appointment Notes, including Questions to Ask the Doctor and Others
- Hospitalization and Outpatient Procedure Information
- Your Test Results
- Chemotherapy and Radiation Schedules
- Pharmacy Information
- Medication Record
- Your Legal Papers
- Second Opinion Information
- Your Bills and Payments
- Notes

Forms in this Patient Record Packet were developed by ‘Imi Hale or adapted from several organizations dedicated to helping people with cancer. These include:

- **The Lance Armstrong Foundation**, through its LIVESTRONG program, offers information, tip sheets and multiple forms for cancer patients.
- **The Wellness Community** provides lots of information and organization tools for cancer patients. Some of their materials are provided.
- **CancerCare.org** provides lists of questions you may want to ask your doctor.
Managing a Cancer Care Record

You have a right to copies of all the paperwork about your healthcare and treatment.

Under the Health Insurance Portability and Accountability Act of 1996 (also called HIPAA), you have the right to get copies of your medical records, x-rays, biological slides, and other stuff related to your cancer.

We recommend that you keep a Patient Record. When you share your record with a health care provider, they don’t have to ask you the same questions over and over again. Each provider will know what the other provider is doing. Your family and Navigator can help you better because all your paperwork is in one place. Keeping a Patient Record can help reduce your stress and save time.

Organize your Paperwork.

- Get something big enough to carry your information, like a 3-ring binder. Use dividers to sort your information.
- Buy plastic-pocket pages that allow you to insert test results and information the doctor gives out. Do not have loose papers!
- Organize records in the order that things happened. The earliest note should be first.
- Your Navigator has “forms” that can help you track your treatment. Because everyone’s cancer is different, and everyone’s treatment is different, your Navigators should only give you the forms that you need.

Create two copies of your Patient Record, just in case one is lost. Take one with you to all appointments, and keep the other at home or in a safe place.

Decide who can have access of your cancer care information. As a person with cancer, you may need help with your records. Think about who can help you collect, organize and update your cancer care information? Who will have access to this information? Where will the information folder be kept so the right people have access to it?
Your Personal Information

Full legal name: ____________________________________________________________

Home Address: ____________________________________________________________________

______________________________________________________________________________

Home ☑: ___________ Work ☑: ___________ Cell ☑: ______________

Employer: ___________________________ Job Title: _____________________________

Work Address: ____________________________________________________________________

______________________________________________________________________________

Personal Identification (Driver’s License, State ID, etc) ____________________________

Father’s name: ___________________________

Mother’s full maiden name: ________________________________________________________
(and whether she took your father’s surname)

Marital status: ___________________________

Spouse/Domestic Partner’s name: _____________________________

Home ☑: ___________ Work ☑: ___________ Cell ☑: ______________

Other contact person(s):

Name: ________________________________ Relationship to you: __________________

Home ☑: ___________ Work ☑: ___________ Cell ☑: ______________

Name: ________________________________ Relationship to you: __________________

Home ☑: ___________ Work ☑: ___________ Cell ☑: ______________

Name: ________________________________ Relationship to you: __________________

Home ☑: ___________ Work ☑: ___________ Cell ☑: ______________
### Your Personal Health History

Use this form to record your past health history. Print out a copy and take it with you to your doctor appointment to help keep your doctor up-to-date.

1. I was in the hospital for (list conditions).  
   
<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

2. I have had these surgeries  
   
<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

3. I have had these injuries, conditions, and illnesses:  
   
<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

4. I have these allergies (list type of allergy—food, medicine, etc.—and reaction):  
   
<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

5. I have had these immunizations (shots):

<table>
<thead>
<tr>
<th>For adults</th>
<th>Suggested age</th>
<th>Date(s) received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza</td>
<td>Every year starting at age 65</td>
<td>__________</td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>Once at age 65</td>
<td>__________</td>
</tr>
<tr>
<td>Tetanus (Td)</td>
<td>Every 10 years</td>
<td>__________</td>
</tr>
</tbody>
</table>

6. I take these medicines / supplements (bring with you, if possible):

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

7. My family members (parents, brothers, sisters, grandparents) have / had these major conditions:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

8. Other notes about your past health and health care.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Source: Choosing a Doctor. Your Guide to Choosing Quality Health Care. AHCPR
http://www.ahrq.gov/consumer/qntascii/qntdr.htm
Your Health Team

Keep a list of all your health care providers, including:

- Family Doctor
- Cancer Doctor (oncologist)
- Surgeon
- Radiation Oncologist
- Chemotherapy Nurse
- Social Worker
- Dietitian
- Any other doctor providing health care for you (not just cancer care).
  - Heart Doctor (cardiologist)
  - Diabetes Doctor (diabetologist, endocrinologist)
  - Etc.
- Complementary and Alternative Medical Care Providers
  - Traditional healers (Kahuna lā`au lapa`au, lomilomi, etc.)
  - Chiropractor
  - Acupuncturist
  - Others
- `Ohana and other care givers
- Spiritual and Religious Workers

Cancer Patient Navigator ________________________________

Agency/Address ____________________________________________

Work ☏: ___________ Cell ☏: ___________ (E-mail) ________________
Helps me with: ________________________________________________
________________________________________________________________
________________________________________________________________
MEDICAL Team

Family Doctor or Internist:

Name: ___________________________________________ Office Hours: ______________
Nurses/Staff names: ___________________________________________
Address: ___________________________________________________________________________
Other offices: ________________________________________________________________________
Phone ☏: _______________ Fax ☏: ___________ (E-mail) ________________
Other phone numbers: __________________________________________________________________
Office Hours: _____________________________________________________________
NOTES: _________________________________________________________________

Other Non-Cancer Doctors, Traditional Healers, and Therapists

Name: ___________________________________________ Office Hours: ______________
Specialty: ________________________________________ Office Hours: ______________
Nurses/Staff names: ___________________________________________
Address: ___________________________________________________________________________
Other offices: ________________________________________________________________________
Phone ☏: _______________ Fax ☏: ___________ (E-mail) ________________
Other phone numbers: __________________________________________________________________
NOTES: _________________________________________________________________

Name: ___________________________________________ Office Hours: ______________
Specialty: ________________________________________ Office Hours: ______________
Nurses/Staff names: ___________________________________________
Address: ___________________________________________________________________________
Other offices: ________________________________________________________________________
Phone ☏: _______________ Fax ☏: ___________ (E-mail) ________________
Other phone numbers: __________________________________________________________________
NOTES: _________________________________________________________________
Cancer Care Doctors:

Name: __________________________________________ Office Hours: __________
Nurses/Staff names: _________________________________________________________
Address: ___________________________________________________________________
Other offices: ________________________________________________________________
Phone ☎: ___________ Fax ☎: ___________ (E-mail) ____________________________
Other phone numbers: _________________________________________________________
Office Hours: __________________________________________________________________
NOTES:

Name: __________________________________________ Office Hours: __________
Specialty: __________________________________________ Office Hours: __________
Nurses/Staff names: _________________________________________________________
Address: ___________________________________________________________________
Other offices: ________________________________________________________________
Phone ☎: ___________ Fax ☎: ___________ (E-mail) ____________________________
Other phone numbers: _________________________________________________________
NOTES:

Name: __________________________________________
Specialty: __________________________________________ Office Hours: __________
Nurses/Staff names: _________________________________________________________
Address: _________________________________________________________________
Other offices: ________________________________________________________________
Phone ☎: ___________ Fax ☎: ___________ (E-mail) ____________________________
Other phone numbers: _________________________________________________________
NOTES:
‘OHANA Team (family, friends, pastor, others)

Name: ____________________________________________
Relation to me: _____________________________ E-mail: __________________
Home ☎: __________ Work ☎: __________ Cell ☎: __________
Helps me with: _____________________________________________________________
____________________________________________________________
____________________________________________________________

Name: ____________________________________________
Relation to me: _____________________________ E-mail: __________________
Home ☎: __________ Work ☎: __________ Cell ☎: __________
Helps me with: _____________________________________________________________
____________________________________________________________
____________________________________________________________

Name: ____________________________________________
Relation to me: _____________________________ E-mail: __________________
Home ☎: __________ Work ☎: __________ Cell ☎: __________
Helps me with: _____________________________________________________________
____________________________________________________________
____________________________________________________________

Name: ____________________________________________
Relation to me: _____________________________ E-mail: __________________
Home ☎: __________ Work ☎: __________ Cell ☎: __________
Helps me with: _____________________________________________________________
____________________________________________________________
____________________________________________________________
<table>
<thead>
<tr>
<th>Name:</th>
<th>Relation to me:</th>
<th>E-mail:</th>
<th>Home ☎:</th>
<th>Work ☎:</th>
<th>Cell ☎:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Health Insurance Information

Primary Insurer: _______________________________________

Subscriber Name: ____________________________________________

Subscriber Number: ___________________ Group Number: __________

Benefits: □ Medical □ Dental □ Drug □ Vision

Insurer Contact Information: _______________________________________

Other Insurer: _______________________________________

Subscriber Name: ____________________________________________

Subscriber Number: ___________________ Group Number: __________

Benefits: □ Medical □ Dental □ Drug □ Vision

Insurer Contact Information: _______________________________________

Other Insurer: _______________________________________

Subscriber Name: ____________________________________________

Subscriber Number: ___________________ Group Number: __________

Benefits: □ Medical □ Dental □ Drug □ Vision

Insurer Contact Information: _______________________________________

Make photocopies of your insurance card(s). Keep them in a plastic-pocket page in this binder. Each doctor’s office will want a copy.
Preparing for Appointments

Use the following Appointment Notes Form to arrange and prepare for your visit to the doctor.

Before your appointment:

✓ Confirm your appointment
✓ Confirm location and how you will get to the appointment
✓ Bring all the paperwork your doctor wants to see
✓ Complete any lab tests/blood work ahead of time
✓ Write a list of questions you or your family may have for the doctor on the form and bring the form to the appointment so you don’t forget to ask.

At your appointment

✓ Bring someone who can help you ask questions and get answers.
✓ Write down what the doctor tells you and what he wants you to do after the appointment. (Or have your kokua (caregiver) write down this information for you.)
✓ Write down the next appointment date with this doctor/health care provider. (Or have your kokua write down this information for you.)
Appointment Notes

With: _______________________________________________  Date: _______ (Day)_________
Location: ___________________________________________  Time: _________ AM  PM

To Do before the appointment:

☐ Put appointment on calendar
☐ Get lab work by this date: _________________
☐ Arrange transportation to appointment
☐ Get directions to the office/place
☐ Decide who will go with me: _________________
☐ Bring these things: ________________________________
Other: ____________________________________________

Questions I need to ask:

1. _______________________________________________
2. _______________________________________________
3. _______________________________________________
4. _______________________________________________

Things I need to do after the appointment:

1. _______________________________________________
2. _______________________________________________
3. _______________________________________________
4. _______________________________________________

Next Appointment?
Date: ___________
Time: ____________
Appointment Notes

With: ________________________________ Date: ________ (Day) ________

Location: ________________________________ Time: ________ AM   PM

To Do before the appointment:

☐ Put appointment on calendar
☐ Get lab work by this date: _________________
☐ Arrange transportation to appointment
☐ Get directions to the office/place
☐ Decide who will go with me: _________________
☐ Bring these things: ________________________________

Other: ___________________________________________________________________________________

________________________________________________________________________________________

Questions I need to ask:

1. ___________________________________________________________________________________
2. ___________________________________________________________________________________
3. ___________________________________________________________________________________
4. ___________________________________________________________________________________

Things I need to do after the appointment:

1. ___________________________________________________________________________________
2. ___________________________________________________________________________________
3. ___________________________________________________________________________________
4. ___________________________________________________________________________________

Next Appointment?
Date: ___________
Time: ___________
Hospitalization Information (1 sheet per hospital stay):

Hospital Name: _____________________________________________________________
Address: __________________________________________________________________
Other offices: __________________________________________________________________
Phone & Fax: __________________________________________________________________E-mail: _________________
Other phone numbers: ____________________________________________________________________

Reason for stay (surgery, chemotherapy, radiation, other): __________________________
Admission date: ___________________    Discharge date: ___________________
Admitting doctor: __________________________
Discharge doctor: __________________________
Doctors who came to see me while there:
   Name: _______________________________  Specialty: ______________________
   Name: _______________________________  Specialty: ______________________
   Name: _______________________________  Specialty: ______________________
   Name: _______________________________  Specialty: ______________________

Take home information:
   □ Discharge Summary
   □ Instructions for care
   □ Appointment with doctor
   □ Medicines to take
   □ Diet instructions
   □ Copies of tests for next appointment

Admission date: _______    Discharge date: _______

NOTES:
Outpatient Procedure Information (1 per procedure)

Facility Name: _____________________________________________________________
Address: __________________________________________________________________
Phone ☏: ______________ Fax ☏: __________ (E-mail) ________________
Other phone numbers: _______________________________________________________

Type of procedure (diagnostic test, outpatient surgery, radiation set up, chemo start, other):
________________________________________________________________________
Date:____________________

Doctor: ____________________ Nurse: ____________________
Others Name: ____________________ Role: ____________________
      Name: ____________________ Role: ____________________
      Name: ____________________ Role: ____________________
      Name: ____________________ Role: ____________________

Take home information:

☐ Discharge Summary
☐ Instructions for care
☐ Appointment with doctor
☐ Medicines to take
☐ Diet instructions
☐ Copies of tests for next appointment

NOTES:
Chemotherapy Schedule

Oncologist: _____________________________________________________________
Facility Name: __________________________________________________________
Address: _______________________________________________________________
Phone ☏: _____________ Fax ☏: _____________ (E-mail) _______________________
Staff and their phone numbers: ____________________________________________

Plan for Chemo: _________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Chemo Schedule:

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Date and Time</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Possible side effects ____________________________________________________
_______________________________________________________________________
_______________________________________________________________________
Between visits, I should call the doctor if: ________________________________
_______________________________________________________________________
_______________________________________________________________________
**Radiation Schedule**

Radiation Oncologist: ______________________________________________________

Facility Name: ____________________________________________________________

Address: __________________________________________________________________

Phone 📞: ___________ Fax 📞: ___________ (E-mail) ____________________________

Staff and their phone numbers: ____________________________________________

Plan for Radiation: _________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

**Radiation Schedule:**

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Date and Time</th>
<th>Date and Time</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Possible side effects ______________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Between visits, I should call the doctor if: _________________________________
__________________________________________________________________________
__________________________________________________________________________
Pharmacy Information:

Pharmacy Name: ___________________________________________________________
Address: __________________________________________________________________
Other locations: __________________________________________________________
Phone ☏: ______________ Fax ☏: ____________ (E-mail) _________________
Other phone numbers: _____________________________________________________
Medicines I get from this pharmacy:

1. ___________________________________________ Prescription # _____________
2. ___________________________________________ Prescription # _____________
3. ___________________________________________ Prescription # _____________
4. ___________________________________________ Prescription # _____________
5. ___________________________________________ Prescription # _____________

NOTES:

Pharmacy Name: ___________________________________________________________
Address: __________________________________________________________________
Other locations: __________________________________________________________
Phone ☏: ______________ Fax ☏: ____________ (E-mail) _________________
Other phone numbers: _____________________________________________________
Medicines I get from this pharmacy:

1. ___________________________________________ Prescription # _____________
2. ___________________________________________ Prescription # _____________
3. ___________________________________________ Prescription # _____________
4. ___________________________________________ Prescription # _____________
5. ___________________________________________ Prescription # _____________

NOTES:
Keeping track of your medicines:

1. Directions on HOW and WHEN to take your medicines can be confusing so write down how your doctor says that you should be using your medications.

   **Caution:** If the prescription says to take the medicine with meals, be certain to find out whether that means one pill with some food at approximately the same time each day or literally one pill at each meal. There is a huge difference between one pill and three pills.

2. Sometimes your physician will give you a trial bottle or sample bottle to get you started. This bottle may not have the usage instructions on it, so it is important to write that information down in your personal notes.

3. Transfer all the prescription information to a single sheet (see form attached).

4. Share that list with your doctor so that he knows what you are already taking. It is likely that you will have more than one doctor for your cancer care and one doctor may not know what your other doctor has prescribed for you.

5. Make sure to have a list of your non-prescription medicines (medicines that you can buy yourself without a doctor’s prescription).

6. From time to time, have your pharmacist review all of your prescription and non-prescription medications and preparations to be certain that there are no bad interactions among them. Your pharmacist likely has a computer with up to date information that your individual doctors may not be aware of, especially about medications that other doctors may be prescribing for you.
## Medication Record

<table>
<thead>
<tr>
<th>Name of medication</th>
<th>FROM WHO/WHERE (Doctor, Kahuna, or Over-the Counter)</th>
<th>When/how do I take it?</th>
<th>Warnings and side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop this medication when: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop this medication when: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop this medication when: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop this medication when: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop this medication when: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>_________________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stop this medication when: _______________</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name:</td>
<td>Stop this medication when:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>______________________</td>
<td>__________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ At bed time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Stop this medication when:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>__________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ At bed time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Stop this medication when:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>__________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ At bed time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Stop this medication when:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>__________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ At bed time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name:</th>
<th>Stop this medication when:</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>__________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With breakfast</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With lunch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Before dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ With dinner</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ At bed time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Your Legal Documents

It is important to make your own wishes known about health treatment. Some people are OK with letting their doctor or family member make health treatment decisions for them. But often, people with cancer feel better once their own wishes are known. Talk with someone close to you about what kind of care you want. The more you know, the more prepared you will be.

**Advance Directives** are legal papers that tell the doctors what to do if you cannot tell them yourself. You can decide ahead of time, how you want to be treated. Advanced Directives may include a living will, durable power of attorney, and Physician’s Orders for Life-Sustaining Treatment (POLST).

- **Living Will.** A living will is a document that lets people know your wishes regarding medical care if you can't speak for yourself. It relieves your family of the guilt and conflict that can come with having to make these types of decisions.

- **Durable Power of Attorney for health care** lets you name someone to make decisions for you in case you cannot. This person is someone you choose and is called a “health care proxy”. It should be a person you trust.

- **Physician’s Orders for Life-Sustaining Treatment (POLST)** tells health care providers, including emergency responders, what treatments you’d like to receive as you near the end of your life. Your health care provider may have copies of the form, or you can download the form and bring it to your next appointment. Your provider will explain the form to you and give you more information about your treatment options.

**Do you need a lawyer?** A lawyer is not always needed to fill out these documents. But you may need a notary public. Each state has its own laws about advance directives.

**What if you and your family do not agree?** Your family members may have different opinions from you, but you have the final decision. It is important to talk early. If you cannot agree, ask someone for help. You might talk to a member of your church, other people dealing with cancer, a trusted family friend, or a hospice worker.

**Advance directives: Completed?** □ Yes □ No

Give copies of your advance directive to your health care team, the hospital medical records department, and the person you choose as your durable power of attorney for health care.

**I have designated this person as my power of attorney:**

Name: ___________________________________________ Relationship __________________________

Address: ____________________________________________________________

Home ☑: _______________ Work ☑: _______________ Cell ☑: _______________
Your Journal or Diary

Many patients have found a journal or diary helpful.

- Coping with the challenges of having cancer by providing a place to vent
- Provides a document of your emotional and physical changes
- A place to express thoughts and feelings that are sometimes difficult to say out loud or discuss with someone
- Provides a document of your cancer care

Each person has a preference about what kind of journal or diary to keep. Some write volumes daily, while others jot down brief notes. Find something that matches your style.
Getting a Second Opinion

Requesting a second opinion is normal, and your doctor should not be offended. Your doctor should appreciate that you are gathering all the information you need to make informed decisions throughout your treatment.

Sometimes you can get different opinions. If there is a difference of opinions, you can consider getting a third consultation.

Getting the most out of a second opinion:

1. Arrange to have a complete set of your medical records and medical reports to share with the doctor making the second opinion. This should include any of the following that you have:
   - MRI – Magnetic Resonance Imaging
   - CT Scan – Computer Tomography
   - PET Scan – Positron Emission Tomography
   - Pathology slides
   - Lab Results

   How to get records:

   a. Ask your doctor or nurse where to get copies of your tests and reports.
   b. The Pathology Lab may need 48 hours notice to make copies of your slides.
   c. There may be a charge for getting copies of your slides so ask.

2. Write down questions you want to ask the doctor and bring the list of questions to the meeting.

3. Bring a friend or family member with you to help you take notes. If it is alright with the doctor, you can record the meeting so that you can refer to the tape when you discuss this later with your family.

What if the opinions of both doctors are different? What if they disagree on how to treat you?

If you get different opinions on your treatment, discuss the pros and cons with the doctor you are most comfortable with. It is standard practice to take the opinion you learn from a “second opinion doctor” back to the first doctor. This happens all the time.

Getting Your Medical Records:

You may need to request a copy of your complete Medical Records if you:

- Seek a second/third opinion
- Apply for disability or extended leave at your job
- Apply for Social Security disability
- Go for evaluation/treatment at a different facility

Doctors prepare reports of each visit. There should be a report for each time you see a physician, physical therapist, or another provider. There should be a report for each checkup, lab test, x-ray, surgery, chemotherapy visit, radiation visit, hospitalization, etc.

If possible, collect copies as you go. Even then, you may have to request your complete Medical Record. Things to get include:

- The note that's added to your chart at each visit to a physician, physical therapist, or other provider for a checkup or treatment
- Each set of lab results
- A written report of each imaging procedure (listed next)
- Imaging films: x-rays, CT scans, MRIs, PET, etc. Remember, these must be kept flat and stored in a cool place. Some results are provided on a CD/DVD
- Each written pathology report
- Discharge summary of each hospitalization
- Tissue blocks and specimen slides.

Getting Your Record. You have the right to your Medical Record. Some facilities may ask you to pay for a copy of your Medical Record. Usually, if your physician requests a copy of your Medical Record, it will be provided at no cost.
**Your Bills and Payments**

- **Collect All your Receipts:**
  - your co-payments (the portions that you pay for)
  - your prescription payments

  You may need to come up with one or more of these receipts on very short notice. Keep them well organized.

- **File the bills by provider, with most current bill on top.**

- **Log all payments you make and to who (form provided).**

**Payments made for my cancer care:**

<table>
<thead>
<tr>
<th>Date Paid</th>
<th>HOW?</th>
<th>Paid to who and what did you pay for</th>
<th>Invoice number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Payments made for my cancer care:

<table>
<thead>
<tr>
<th>Date Paid</th>
<th>HOW?</th>
<th>Paid to who and what did you pay for</th>
<th>Invoice number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Quick Contact List

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name: _____________________________</th>
<th>Work ☎: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cell ☎: ___________________</td>
</tr>
<tr>
<td></td>
<td>Email: ___________________</td>
</tr>
</tbody>
</table>