DOH CANCER MEDICINE ACCESS PROGRAM

Patient Follow-up Form After Completion of Therapy during Each Follow-up Care for 5 or more years (CMAP F4)

(Fill-up by Physician; any lab or imaging results attached by navigator to this form)

DATE	**CMAP ID (Year-Pt #): _____**		
PATIENT NAME			
Primary Cancer Site & Histology			
		Stage	
1st Definitive Surgery		**Specify procedure, Date**	
1st Line Chemotherapy regimen		**Date start/ Date end**	**Total # of cycles:**
1st Definitive Radiotherapy		**Date start/end:**	**Total cGy Dose:**
ECOG		Height:	Weight:

MEDICAL EVALUATION:

Is the baseline **co-morbidity** worsening? Y/N, specify _____

Is **cancer disease** progressing? (Y/N) _____

If Y, Fill-up table

Disease progression symptom/mets site/abn test	Test done	Date done	Comments

Was a re-biopsy done? Y/N ____ If Y, Date: _____

Treatment Plan/ History:

2nd Line Drug (Y/N) _____ Date started: _____Date ended:_____

If Y, what drug regimen _____ Response: ____

Radiotherapy (Y/N) _____ If Y, Date/ Specify: _____

Surgery (Y/N), _____ If Y, Date/ Specify: _____

3rd Line Drug (Y/N) _____ Date started: _____Date ended:_____

If Y, what drug regimen _____ Response: ____

Radiotherapy (Y/N) _____ If Y, Date/ Specify: _____

Surgery (Y/N) _____ If Y, Date/ Specify: _____

4th Line Drug (Y/N) _____ Date started: _____Date ended:_____

If Y, what drug regimen _____ Response: ____

Radiotherapy (Y/N) _____ If Y, Date/ Specify: _____

Surgery (Y/N) _____ If Y, Date/ Specify: _____

Notes: _____

Survival data:

Patient still alive as of date: _____

Patient died on date: _____

Cause of death: _____