Date:_______/_______/_______ **Name:**______________________
(month) (day) (year)

Your Health Care Team and You Working Together:
THE CANCER SURVEILLANCE PRESCRIPTION

At your visit, we talked about important actions that you can take to help with your post-treatment cancer care. This tool is a summary of our discussion, including next steps that we can take together to improve your health and well-being.

Screening For:	Test Date:	Target:	Re-Check:	Referrals/Actions:
Breast Cancer	Enter month and year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
Mammogram	/	Every year**		
MRI	/	Every year		
SERMs Rec.				
Eligible for DEXA				
Colorectal Cancer	Enter month and year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
Colonoscopy	/	Every 5 years**		
CEA	/	Every 6mo for 5yrs**		
CT Scan	/	Every year for 3yrs**		
Rectosigmoidoscopy	/	Every 6mo for 2-5yrs**		
Prostate Cancer	Enter month and year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
PSA	/	Every 6-12mo for 5yrs, then yearly**		
Assess Fracture Risk				
Bone Health	Enter month and year of last test		Enter year or time frame	Enter referrals made or action items for patient or clinician
DEXA Scan	/	Every 2-3yrs		
Vitamin D	IU/day	800 - 1000 IU/day**		
Calcium	mg/day	1000-1200 mg/day**		
Lifestyle			Enter year or time frame	Enter referrals made or action items for patient or clinician
Alcohol		Avoid		
Other Concerns			Enter year or time frame	Enter referrals made or action items for patient or clinician
Medical Exam	/			
Depressed Mood				
Anxious/Worrying				
Distress				
Long-term Effects/ Symptoms				
Symptoms of Recurrence				

**These are normal screening intervals. Review patient risk status to determine if they are at elevated risk.

Patient has possible risk of recurrence: Breast Cancer: ◉ YES / NO ○

SAVE RESET

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