

After treatment, it is important to have follow-up visits to check whether breast cancer or DCIS has come back, to monitor side effects of treatment and to provide practical and emotional support.

Information in this Shared Care Plan will help your GP and specialists manage your follow-up care together.

Please take the Shared Care Plan with you when you visit your GP, specialist or another member of your treatment team. Ask them to record the outcomes of follow-up tests and any actions to be taken.

**If you notice any new or unusual symptoms between follow-up appointments, do not wait until your next scheduled appointment. See your GP as soon as possible so that the cause of the symptom can be explored.**

This Shared Care Plan:

- is only to be used by patients, GPs, specialists, other health providers and sites as part of the National Breast and Ovarian Cancer Centre's *Shared care demonstration project*
- is not intended to be a complete patient history or treatment plan and does not replace the need for ongoing professional medical advice
- is not to be used as a substitute for existing referral arrangements between GPs, specialists and other health professionals
- will become active after review and sign-off by the patient, GP and specialist.

### PATIENT DETAILS & CONTACT INFORMATION

Patient name			Date of birth	/	/
Address			Mobile no.		
	State	Postcode	Home / Work no.		
Support contact					
Relationship		Mobile no.		Home / Work no.	
GP name					
Practice address			Phone no.		
	State	Postcode	Fax no.		
Email address					
Specialist name			Speciality		
Address			Phone no.		
	State	Postcode	Fax no.		
Email address					

### COMMENCEMENT OF SHARED CARE

Patient agreement	I have agreed to this Shared Care Plan.				
	Patient's signature _____	Date	/	/	
Health professional agreements	I have reviewed this Shared Care Plan.				
	GP's signature _____	Date	/	/	
	Specialist's signature _____	Date	/	/	
Case conference attended?	<input type="checkbox"/> Yes <input type="checkbox"/> No				

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Patient name

**DIAGNOSIS & HISTORY SUMMARY**

To be completed by the specialist

Diagnosis date  /  /  Age at diagnosis

Position  Left  Right

Histological diagnosis  Size (mm)   
Grade  1  2  3

Receptor status  Oestrogen Receptor +ve  Progesterone Receptor +ve  HER2 Receptor +ve

Menopausal status at commencement of shared care  Pre  Peri  Post  Unknown

Family history Include the number of affected maternal and paternal relatives, and indicate whether breast or ovarian cancer. If none, tick here

	Maternal relatives		Paternal relatives	
	Breast	Ovarian	Breast	Ovarian
1°	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
2°	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>
Distant	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>	<input style="width: 40px;" type="text"/>

Genetic counselling  No  Yes (provide details) Date / /

Other health conditions/ relevant information\*

Current medications

Known allergies

\* Include details of additional known factors that may impact on patient's risk of recurrence or approach to follow-up care.

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Patient name	
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### TREATMENT SUMMARY

To be completed by the specialist

#### Surgery

Breast surgery	<input type="checkbox"/> Breast conserving surgery	<input type="checkbox"/> Mastectomy (unilateral or bilateral)	Date	/	/
Axillary surgery	<input type="checkbox"/> Sentinel node biopsy	<input type="checkbox"/> Axillary clearance	<input type="checkbox"/> Other _____	Date	/ /
No. removed		No. positive			
Surgeon name				Phone no.	
Reconstruction	Method of breast reconstruction _____			Date	/ /
Surgeon name				Phone no.	

#### Radiotherapy

Start date	/ /	End date	/ /	
Field	<input type="checkbox"/> Breast	<input type="checkbox"/> Axilla	<input type="checkbox"/> Chest wall	<input type="checkbox"/> Other (please specify) _____
Radiation oncologist name			Phone no.	

#### Systemic therapy

Chemotherapy type	Start date	/ /
	End date	/ /
Hormonal therapy type	Start date	/ /
	End date*	/ /
Targeted therapy type	Start date	/ /
	End date	/ /
Medical oncologist name	Phone no.	

#### Other issues

Issues requiring other specialist / allied health involvement	
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#### Other specialists / allied health providers consulted

Name & speciality	Phone no.
Name & speciality	Phone no.
Name & speciality	Phone no.

\* End date for hormonal therapy may be in the future.

Patient name	
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**RECOMMENDED FOLLOW-UP SCHEDULE**

- To be completed and agreed by the specialist and GP at commencement of shared care to document all planned monitoring.
- The standard follow-up schedule recommended by NBOCC is provided below to plan follow-up appointments.

Time since diagnosis	Date	Purpose of Visit	Provider Name & Speciality
<b>Years 1–2 Breast cancer follow-up</b> • History and clinical breast examination (CBE) every 3–6 months, and • Breast imaging (mammogram and/or ultrasound) every 12 months	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
Other planned reviews / monitoring as clinically required*	/ /		
	/ /		
	/ /		
<b>Years 3–5 Breast cancer follow-up</b> • History and clinical breast examination (CBE) every 6–12 months, and • Breast imaging (mammogram and/or ultrasound) every 12 months	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
	/ /		
Other planned reviews / monitoring as clinically required*	/ /		
	/ /		
	/ /		
<b>After 5 years Breast cancer follow-up</b> • History and clinical breast examination (CBE) every 12 months, and • Breast imaging (mammogram and/or ultrasound) every 12 months	/ /		
	/ /		
	/ /		
	/ /		
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	/ /		
Other planned reviews / monitoring as clinically required*	/ /		
	/ /		
	/ /		

\* This may, for example, include a bone density (DXA) scan.


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Patient name	
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### FOLLOW-UP VISITS & OUTCOMES

To be completed by the health professional (GP or specialist) who is the provider of the scheduled follow-up visit. Start a new page for each follow-up visit.

Time since diagnosis	Months	Years	
Provider name			Date / /
Patient name			
Date of birth	/ /	Mobile no.	Home/Work no.
Address			State Postcode

Follow-up aims	Completed	Outcome / issues identified at this visit
Check for symptoms or signs of <b>local</b> or <b>regional</b> recurrence	<input type="checkbox"/>	
Ask about symptoms of <b>distant</b> recurrence	<input type="checkbox"/>	
Identify psychosocial issues	<input type="checkbox"/>	
Identify side effects of treatment	<input type="checkbox"/>	
Update family history	<input type="checkbox"/>	
Update menopausal status	<input type="checkbox"/>	
Update other health conditions	<input type="checkbox"/>	
Review medications	<input type="checkbox"/>	
Discuss secondary prevention of breast cancer	Diet <input type="checkbox"/>	
	Exercise <input type="checkbox"/>	
	Alcohol <input type="checkbox"/>	

### INVESTIGATIONS & REFERRALS

Breast imaging							
Mammogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Referral given	/	/	Results received	/ /
	Result*					Next imaging due	/ /
Ultrasound	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Referral given	/	/	Results received	/ /
	Result*					Next imaging due	/ /
Other investigations							
Referrals following this visit							
Rapid access request indicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No				Next follow-up visit	/ /


\* Add breast imaging classification (1–5) if included in imaging report. National Breast Cancer Centre (2007). *Synoptic breast imaging report*. Camperdown, NSW, NBCC.

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Patient name		
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Address	State	Postcode

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Identify side effects of treatment	<input type="checkbox"/>	
Update family history	<input type="checkbox"/>	
Update menopausal status	<input type="checkbox"/>	
Update other health conditions	<input type="checkbox"/>	
Review medications	<input type="checkbox"/>	
Discuss secondary prevention of breast cancer	Diet	<input type="checkbox"/>
	Exercise	<input type="checkbox"/>
	Alcohol	<input type="checkbox"/>

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Breast imaging						
Mammogram	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Referral given	/ /	Results received	/ /
	Result*				Next imaging due	/ /
Ultrasound	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Referral given	/ /	Results received	/ /
	Result*				Next imaging due	/ /
Other investigations						
Referrals following this visit						
Rapid access request indicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Next follow-up visit		/ /	


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Patient name		
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Update menopausal status	<input type="checkbox"/>	
Update other health conditions	<input type="checkbox"/>	
Review medications	<input type="checkbox"/>	
Discuss secondary prevention of breast cancer	Diet	<input type="checkbox"/>
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	Result*				Next imaging due	/ /
Ultrasound	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Referral given	/ /	Results received	/ /
	Result*				Next imaging due	/ /
Other investigations						
Referrals following this visit						
Rapid access request indicated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Next follow-up visit		/ /	

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**OUTCOME OF CONSULTATIONS WITH OTHER HEALTH PROVIDERS**

Provider Name		Speciality	
Assessment and management plan			
Date	/ /	Signature	Date of review
			/ /
Provider Name		Speciality	
Assessment and management plan			
Date	/ /	Signature	Date of review
			/ /
Provider Name		Speciality	
Assessment and management plan			
Date	/ /	Signature	Date of review
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Provider Name		Speciality	
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Provider Name		Speciality	
Assessment and management plan			
Date	/ /	Signature	Date of review
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