

BREAST CANCER MANAGEMENT PLAN



Patient's Name:

Patient problems / needs / relevant conditions	Goals – changes to be achieved	Required treatments and services including patient actions	Arrangement for treatments / services (when, who, contact details)
1. General			
<input type="checkbox"/> Patient's understanding of their condition	<input type="checkbox"/> Patient to have a clear understanding of their condition and patient's role in management.	<input type="checkbox"/> Patient education	<input type="checkbox"/> GP / Nurse <input type="checkbox"/> Educator
2. Lifestyle			
<input type="checkbox"/> Nutrition	<input type="checkbox"/> Maintain healthy diet	<input type="checkbox"/> Patient Education OR <input type="checkbox"/> as per Lifescripts action plan	<input type="checkbox"/> Patient to implement <input type="checkbox"/> GP to monitor <input type="checkbox"/> Dietitian
<input type="checkbox"/> Weight	Your target: BMI< Ideal: BMI ≤ 25 kg/m ²	<input type="checkbox"/> Monitor <input type="checkbox"/> Review 6-monthly OR <input type="checkbox"/> as per Lifescripts action plan	<input type="checkbox"/> Patient to monitor <input type="checkbox"/> GP to review
<input type="checkbox"/> Physical Activity	Your target: Ideal: Exercise at least 30 minutes walking or equivalent 5 or more days per week	<input type="checkbox"/> Patient exercise routine OR <input type="checkbox"/> as per Lifescripts action plan	<input type="checkbox"/> Patient to implement <input type="checkbox"/> GP to review <input type="checkbox"/> Exercise Physiologist
<input type="checkbox"/> Smoking	<input type="checkbox"/> Complete cessation	<input type="checkbox"/> Smoking cessation strategy: Consider: <input type="checkbox"/> QUIT <input type="checkbox"/> Medication OR <input type="checkbox"/> as per Lifescripts action plan	<input type="checkbox"/> Patient to manage <input type="checkbox"/> GP to monitor and support
<input type="checkbox"/> Alcohol intake	Your target: < standard drinks per day Ideal: ≤ 2 standard drinks per day (men) ≤ 1 standard drink per day (women)	<input type="checkbox"/> Reduce alcohol intake <input type="checkbox"/> Patient education OR <input type="checkbox"/> as per Lifescripts action plan	<input type="checkbox"/> Patient to manage <input type="checkbox"/> GP to monitor and support

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3. Post breast cancer care			
<input type="checkbox"/> Psychosocial	<input type="checkbox"/> Early detection & intervention	<input type="checkbox"/> Monitor	<input type="checkbox"/> GP/Nurse <input type="checkbox"/> Psychologist <input type="checkbox"/> Breastcare Nurse
<input type="checkbox"/> Examination	<input type="checkbox"/> Early detection of recurrence <input type="checkbox"/> Early detection of new primary breast cancer <input type="checkbox"/> Early detection of new secondary breast cancer <input type="checkbox"/> Early detection of lymphoedema	<input type="checkbox"/> Review annually or as symptoms present <input type="checkbox"/> Lymphoedema management	<input type="checkbox"/> Lymphoedema clinic <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Surgeon <input type="checkbox"/> Oncologist <input type="checkbox"/> GP
<input type="checkbox"/> Imaging	<input type="checkbox"/> Early detection of recurrence <input type="checkbox"/> Early detection of new primary breast cancer	<input type="checkbox"/> Annual mammography <input type="checkbox"/> Ultrasound if indicated	<input type="checkbox"/> GP <input type="checkbox"/> Surgeon <input type="checkbox"/> BreastScreen (after 5 years)
4. Medication			
<input type="checkbox"/> Medication review	<input type="checkbox"/> Correct use of medications <input type="checkbox"/> Minimise side effects <input type="checkbox"/> SERMs (Tamoxifen) <input type="checkbox"/> Aromatase inhibitors (Arimidex) <input type="checkbox"/> Herceptin	<input type="checkbox"/> Patient education <input type="checkbox"/> Review medication <input type="checkbox"/> Endometrial biopsy (Tamoxifen) <input type="checkbox"/> Bone densitometry (Arimidex) <input type="checkbox"/> Echocardiography (Herceptin)	<input type="checkbox"/> GP to review and provide education <input type="checkbox"/> Gynaecology referral <input type="checkbox"/> Radiology referral

Copy of GPMP offered to patient? Yes No

Copy / relevant parts of the GPMP supplied to other providers? Yes No

GPMP added to the patient's records? Yes No

Date service was completed: _____ / _____ / _____

Review Date: _____ / _____ / _____

Does the patient require and qualify for a Team Care Arrangement service? Yes No

I have explained the steps and costs involved, and the patient has agreed to proceed with the service.

GP's Signature _____

Date: _____ / _____ / _____

Patient's Name:

Date of Birth:

Contact Details:.....

Medicare or Private Health Insurance Details:

Details of Patient's Usual GP:

Details of Patient's Carer (if applicable):

Date of last Care Plan / GP Management Plan (if done):/...../.....

If the patient has a previous or existing care plan, when was it prepared and what were the outcomes?.....

Other notes or comments relevant to the patient's management plan:.....

MEDICATIONS

ALLERGIES