



Living with NETs

Neuroendocrine tumours information & support

Your Medical Details and Treatment Tracker

This document is intended to help you keep a record of important details that you may need to share with healthcare professionals throughout your Living with Neuroendocrine Tumours (NETs) journey. Take a copy with you to your various appointments and ask your healthcare professionals to help you complete it.

Date:.....

About You	
Write down your name and contact details here and the name and phone number of someone to contact in an emergency such as a family member or close friend.	
First Name:	
Last Name:	
Date of Birth:	
Phone:	
Email:	
Emergency Contact: (Name/Phone Number)	



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Your NETs History	
Make a note of your NETs history here, such as the date you were first diagnosed, the type of NETs that you have and where these are located. Ask your healthcare team to help you fill in this section if needed.	
Date of Your Diagnosis: <i>(Day, month, year)</i>	
Who Made the Diagnosis? <input type="checkbox"/> Primary care doctor <input type="checkbox"/> Endocrinologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Other	
Location of NETs <input type="checkbox"/> Appendix <input type="checkbox"/> Rectum <input type="checkbox"/> Colon <input type="checkbox"/> Stomach <input type="checkbox"/> Lung <input type="checkbox"/> Small intestine <input type="checkbox"/> Pancreas <input type="checkbox"/> Unknown (primary not found) <input type="checkbox"/> Other, please specify.....	
Details of the tumor: Stage [] Grade [] Metastasized <input type="checkbox"/> Yes <input type="checkbox"/> No Location:	
Other information about your NETs:	



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Your Treatment Plan

Ask a member of your healthcare team to help you complete this section and make a note of the treatments you have or will receive.

Treatment Goal:

Treatments Received:

Surgery

Date of surgery:

Type of surgery:

Location of surgery:

Outcome of surgery:

Radiation Therapy

Type of radiation therapy:

Dose and radiation schedule:

Date of first treatment:

Date of last treatment:



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Outcome of radiation therapy:

Chemotherapy

Name of medication:

Dose and frequency:

Date of first treatment:

Date of last treatment:

Outcome of chemotherapy:

Medical Therapy

Name of medication:

Dose and frequency:

Date of first treatment:

Date of last treatment:

Outcome of medical therapy:

Other treatments received:



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Your Healthcare Professionals	
Write down the names and contact details of the healthcare professionals in your multidisciplinary team here, such as the name of your primary care doctor and nurse, specialist NET doctor and others who are involved in your care.	
Primary care doctor	
Name:	
Practice address:	
Telephone:	
Email:	
Endocrinologist	
Doctor's name:	
Clinic or hospital address:	
Telephone:	
Email:	
Gastroenterologist	
Doctor's name:	
Clinic or hospital address:	
Telephone:	
Email:	



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Surgeon	
Name:	
Clinic or hospital address:	
Telephone:	
Email:	
Radiation Oncologist	
Name:	
Clinic or hospital address:	
Telephone:	
Email:	
Medical Oncologist	
Name:	
Clinic or hospital address:	
Telephone:	
Email:	
Nurse	
Name:	
Practice address:	
Telephone:	
Email:	



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Name:	
Clinic or hospital address:	
Telephone:	
Email:	
Name:	
Clinic or hospital address:	
Telephone:	
Email:	
Name:	
Clinic or hospital address:	
Telephone:	
Email:	
Name:	
Clinic or hospital address:	
Telephone:	
Email:	



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Your General Health			
<p>Make a note of your general health and any other specific health issues here, such as if you are allergic to a particular medication or have been diagnosed with other medical conditions such as high blood pressure, high cholesterol, asthma or diabetes.</p>			
Do you have any allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't know
Describe any allergies you may have here (e.g., allergic to penicillin)		
Other than NETs, do you have any other long-term medical conditions for which you receive treatment?	<input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) <input type="checkbox"/> Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Heart disease <input type="checkbox"/> Irritable bowel syndrome (IBS) or inflammatory bowel disease (e.g. ulcerative colitis, Crohn's disease) <input type="checkbox"/> Other, please specify.....		
List any medications you may be taking here	Name of medication..... Reason..... Dose and frequency..... Name of medication..... Reason..... Dose and frequency.....		



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How tall are you?	<input type="checkbox"/> meters and <input type="checkbox"/> cm <i>or</i> <input type="checkbox"/> Feet <input type="checkbox"/> inches
What is your current weight?	<input type="checkbox"/> Kg or <input type="checkbox"/> stones and <input type="checkbox"/> pounds
How many alcoholic drinks do you have in an average week?	<input type="checkbox"/> I do not drink <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3-5 <input type="checkbox"/> 5-10 <input type="checkbox"/> 10 or more
Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other (list any other information you think might be important here):	



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Your Notes

Make any additional notes here, such as any questions you would like to ask at your next appointment or any concerns that you may have regarding Living with NETs.

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