***BREAST***

**WCH-PMH AFTER CANCER TREATMENT TRANSITION CLINIC**

**(ACTT) 76 Grenville St. Toronto, ON M5S 1B2 5th floor**

**ACTT CLINIC FAX# 416-323-6001**

**ACTT PHONE#: 416-323-6400 EXT 3297**

 **Translator required □ No □ Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACTT Clinic Visit in \_\_\_\_ Months**

**Eligibility (all 4 criteria required): □ Invasive CA □ within 5 years of cancer Dx □ on Endocrine Therapy □ patient primary address in M postal code**

**Last Mammogram (MM/YY) \_\_\_\_/\_\_\_\_\_ Location\_\_\_\_\_ □ ACTT to organize: date \_\_\_\_\_\_**

**Breast Cancer: □ IDC □ DCIS □ Lobular □ Mammary □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **□ Left □ Right □ Bi-Lat Size of Tumor:­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_ nodes**

**Receptor Status: (check if positive) □ ER □ PR □ HER2**

**Date of Diagnosis (MM/YY):** \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **MM/ YY** | **Type** |
|  **/** |  |
|  **/** |  |
|  **/** |  |

**Surgical** **Procedures**

**Chemotherapy □ N/A □ FEC-D □ TC □ AC-TAXOL □ Herceptin □ Other\_\_\_\_\_\_\_\_**

**Radiation □ N/A** **□ Yes #\_\_\_\_\_\_\_\_Fractions Zoledronic Acid □ Yes #\_\_\_\_\_\_Cycles**

**Date Treatment Complete (**MM/YY**) \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
|  **Start** |  **End** |  **Agent** |
|  **/** |  **/** |  |
|  **/**  |  **/** |  |
|  **/** |  **/** |  |

**Hormonal Therapy:**

**□ No □ Yes**

**Recommend Switch to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Expected date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Hormonal Therapy Planned Finish Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POST TREATMENT or SCREENING issues (e.g. lymphedema, low bone mass, BRCA/High risk screen, extended hormonal treatment) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Med Onc □ Surg Onc □ Rad Onc**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_**