World Eye Cancer Hope

life and sight for every child

Retinoblastoma Survivor

Treatment Summary

Care for Life

Patient Name

Date of Birth

Primary Doctor

This Summary Was Completed By

Name

Position

Hospital

Date

General Retinoblastoma Information

Diagnosis

Date of Diagnosis: ______________________________
DD/MMM/YYYY

Age at Diagnosis: ______________________________
in weeks or months

Laterality: ☐ Left ☐ Right ☐ Bilateral ☐ Trilateral

Stage at Diagnosis: Left:______________ Right:______________
IIRC, TNM or RE classification for each eye, if known

Ophthalmologist Details

Name: ______________________________

Hospital: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Pager: ______________________________

Email: ______________________________

Oncologist Contact Details

Name: ______________________________

Hospital: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Pager: ______________________________

Email: ______________________________

Treatment Summary

Main Treatment Centre

Name: ______________________________

Key Contact: ______________________________

Position: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Pager: ______________________________

Email: ______________________________

Secondary Treatment Centre (if shared care)

Name: ______________________________

Key Contact: ______________________________

Position: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Pager: ______________________________

Email: ______________________________

Key Treatment Dates

Initial Treatment: Start: ______________ End: ______________
DD/MMM/YYYY DD/MMM/YYYY

First Relapse: ______________________________
DD/MMM/YYYY

Treatment: Start: ______________ End: ______________
DD/MMM/YYYY DD/MMM/YYYY

Second Relapse: ______________________________
DD/MMM/YYYY

Treatment: Start: ______________ End: ______________
DD/MMM/YYYY DD/MMM/YYYY

Third Relapse: ______________________________
DD/MMM/YYYY

Treatment: Start: ______________ End: ______________
DD/MMM/YYYY DD/MMM/YYYY

Fourth Relapse: ______________________________
DD/MMM/YYYY

Treatment: Start: ______________ End: ______________
DD/MMM/YYYY DD/MMM/YYYY

Enucleation Surgery – Left Eye

Date of Surgery: ______________ Surgeon: ______________
DD/MMM/YYYY

Hospital: ______________________________

Implant Inserted: ☐ Yes ☐ No

Type of Implant: ______________________________

Pathology: ☐ Negative ☐ Optic nerve ☐ Choroid/sclera

Pathology Staging: ______________________________
TNM classification, if known

Enucleation Surgery – Right Eye

Date of Surgery: ______________ Surgeon: ______________
DD/MMM/YYYY

Hospital: ______________________________

Implant Inserted: ☐ Yes ☐ No

Type of Implant: ______________________________

Pathology: ☐ Negative ☐ Optic nerve ☐ Choroid/Sclera

Pathology Staging: ______________________________
TNM classification, if known

Central Venous Catheter

Type of Line: ☐ Port ☐ External Line Other: ____________________

Date of Surgery: ____
DD/MMM/YYYY

Surgeon: ____

Hospital: ____

Complications: ____

____

Date of Removal: ____
DD/MMM/YYYY

Chemotherapy

Clinical Trial Name: ____

Clinical Trial #: ____

Main Investigator: ____

Protocol Attached: ☐ Yes ☐ No

Number of Cycles: ______________

Drug Name	Dates	Dose	Method of Delivery

Radiotherapy

Date of Treatment: ______________________________
DD/MMM/YYYY

Treatment Centre: ______________________________

Key Contact: ______________________________

Position: ______________________________

Address: ______________________________

____

Telephone: ______________________________

Fax: ______________________________

Pager: ______________________________

Email: ______________________________

Clinical Trial Name: ______________________________

Clinical Trial #: ______________________________

Main Investigator: ______________________________

Protocol Attached: ☐ Yes ☐ No

Area Treated: ☐ L Eye ☐ R Eye ☐ Both ☐ Orbital

Type: ☐ Whole Eye ☐ Lens Sparing

# of Sessions: ______________ Total Dose: ______________

Age at treatment: __________

Radioactive plaque

Dates: Inserted: ______________ Removed: ______________
DD/MMM/YYYY DD/MMM/YYYY

Eye Treated: ☐ Left ☐ Right ☐ Both

Type: ☐ Iodine-125 ☐ Ruthenium-106

Total Dose: ______________ Age at treatment: ______________

Stem Cell Transplant

Date of Transplant: ____________________
DD/MMM/YYYY

Transplant Centre: ____________________

Transplant Doctor: ____________________

Address: ____________________

____

Telephone: ____________________

Fax: ____________________

Pager: ____________________

Email: ____________________

Clinical Trial Name: ____________________

Clinical Trial #: ____________________

Main Investigator: ____________________

Protocol Attached: ☐ Yes ☐ No

Type: ☐ Autologous ☐ Allogenic ☐ Syngenic

Conditioning Therapy

Chemo Drug Name	Dates	Dose	Method of Delivery
Radiotherapy	**Dates**	**Total Dose**	**Treatment Centre**

Complications / Long Term Side Effects

Complication	Date Diagnosed	Treatment	Treating Physician

Recommended Follow Up

CT, bone scans and other x-rays are not recommended for routine imaging in children with a known or suspected constitutional RB1 mutation.

E.U.A.: ______________________________

____

Retinal Office Exams: ______________________________

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Oncology: ______________________________

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M.R.I.: ______________________________

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L.P.: ______________________________

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B.M.A.: ______________________________

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Notes

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**For further information about retinoblastoma,
visit World Eye Cancer Hope online at**

www.wechope.org

WE C Hope