

# Caregiver's Logbook with a focus on the cancer patient

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Make it easy to find and share your loved one's health information by recording it all in one place.



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# Information about the patient

Full name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_

Insurance information \_\_\_\_\_ Date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Emergency contact

Name \_\_\_\_\_

Cell phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  Call this number first

Home phone (\_\_\_\_) - \_\_\_\_ - \_\_\_\_  Call this number first

**Call 9-1-1 in the event of a serious or life-threatening emergency.**

## Portal login information

Website \_\_\_\_\_

Username \_\_\_\_\_

Password \_\_\_\_\_

# Important health information:

## Medical conditions

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## Allergies

(for example,  
medicine, food, or latex)

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## Dietary restrictions

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## Physical, verbal, hearing, or visual limitations

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# Locations of important paperwork

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## Driver's license

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## Insurance card

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## Dental benefits card

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## Vision benefits card

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## Pharmacy benefits card

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## Other insurance (disability, long-term care, etc.)

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### Advance directives (living will)

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### Do Not Resuscitate (DNR) paperwork

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### Will/trust

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### Contact information for lawyer

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### Contact information for accountant

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### Contact information for religious advisor

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# Daily routine

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Maintaining a routine can help you ensure that your loved one's care is consistent and that his or her needs are being met on a daily basis. Write down your loved one's daily routine, including meals, medications, and activities.

## Morning

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## Afternoon

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## Evening

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## Night

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Things he or she likes (including any foods, TV/radio programs, or activities)

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Daily chores

Pets

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### Other tasks your loved one needs help with

Task	Person helping	Phone number
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

### Additional people who can help

Name	When available	Phone number
1. _____	1. _____	1. _____
2. _____	2. _____	2. _____
3. _____	3. _____	3. _____

Other notes

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# The cancer care team

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## Primary care/family doctor

Name \_\_\_\_\_

Office phone \_\_\_\_\_

Address \_\_\_\_\_

Nurse \_\_\_\_\_

or receptionist \_\_\_\_\_

Fax number \_\_\_\_\_

E-mail address \_\_\_\_\_

Website \_\_\_\_\_

## Medical oncologist

Name \_\_\_\_\_

Office phone \_\_\_\_\_

Address \_\_\_\_\_

Nurse \_\_\_\_\_

or receptionist \_\_\_\_\_

Fax number \_\_\_\_\_

E-mail address \_\_\_\_\_

Website \_\_\_\_\_

## Radiation oncologist

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

## Surgical oncologist

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_



### Nurse navigator

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

### Cancer social worker

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

### Pharmacist

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

## Preferred hospital

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

## Specialist #1

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_



## Specialist #2

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

## Infusion center

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_

## Lab facility

Name \_\_\_\_\_  
Office phone \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_  
Nurse  
or receptionist \_\_\_\_\_  
Fax number \_\_\_\_\_  
E-mail address \_\_\_\_\_  
Website \_\_\_\_\_



## Information to help prepare for doctor visits

Use this form every time your loved one has to visit a doctor.

### General information

Date and time of visit

Office phone

With (doctor's name)

Covered by insurance

Yes

No

Where

Copay amount

Reason for visit

Health changes, symptoms, or side effects since last visit

Questions to ask the doctor

## 4 quick appointment tips

1 Come prepared

3 Ask questions

2 Take notes (use the next page)

4 Don't be shy





# Notes from doctor visits

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## General information

Date of visit

With (doctor's name)

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Reason for visit

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What did the doctor say during the visit?

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Procedures or tests performed during visit

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Procedures or tests scheduled for after the visit

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Next appointment \_\_\_\_\_





# Notes about possible treatments

You may need to find out about treatment options for your loved one. Use this sheet to gather information and any questions you may have.

Treatment	_____
Pros	_____
Cons	_____
More information	_____
Questions to ask the doctor	_____
	_____

Treatment	_____
Pros	_____
Cons	_____
More information	_____
Questions to ask the doctor	_____
	_____

Treatment	_____
Pros	_____
Cons	_____
More information	_____
Questions to ask the doctor	_____
	_____





## Notes from treatment visits

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Date of treatment	_____
Length of treatment	_____
Treatment center	_____
Address	_____ _____
Phone	_____
Additional treatments required	_____
Notes	_____ _____ _____ _____ _____

## Things to pack for treatment visits

- |   |   |
|---|---|
| <input type="checkbox"/> Comfortable clothing             | <input type="checkbox"/> Entertainment    |
| <input type="checkbox"/> A personal pillow and/or blanket | <input type="checkbox"/> Snacks and water |
| <input type="checkbox"/> Reading materials                | <input type="checkbox"/> Notebook         |



# Symptoms and side effects tracker

Record your loved one's symptoms and side effects. This can help you communicate what he or she is experiencing to other members of the cancer care team.

Week of \_\_\_\_\_ Treatment received \_\_\_\_\_

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Symptoms/ side effects							
Severity (Use a scale of 1 to 10, with 1 being the best and 10 the worst)							
Other notes/ questions	_____ _____						

Week of \_\_\_\_\_ Treatment received \_\_\_\_\_

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Symptoms/ side effects							
Severity (Use a scale of 1 to 10, with 1 being the best and 10 the worst)							
Other notes/ questions	_____ _____						

Some side effects can be more serious than others. If you think your loved one is experiencing a symptom or side effect that requires immediate attention, call the doctor's emergency number or 9-1-1.





## Prescription and over-the-counter medicines your loved one takes

Write down the names of any prescription and over-the-counter medicines (such as aspirin or cough syrup) that your loved one is taking and the reason for taking it.

Medicine	Dosage amount	How and when to take it	Reason for taking it	Prescribing physician	Pharmacy
Name	Number of pills, capsules, drops, etc.	How to take medicine and the time(s) to take it	Reason for taking it. If stopped, give reason for stopping	Name, phone	Name, phone
Description					
Rx #					
# of Refills					
Name	Number of pills, capsules, drops, etc.	How to take medicine and the time(s) to take it	Reason for taking it. If stopped, give reason for stopping	Name, phone	Name, phone
Description					
Rx #					
# of Refills					
Name	Number of pills, capsules, drops, etc.	How to take medicine and the time(s) to take it	Reason for taking it. If stopped, give reason for stopping	Name, phone	Name, phone
Description					
Rx #					
# of Refills					

### Tip

Post this list on the refrigerator or bulletin board so it's always easy to access.



## Vitamins, supplements, and herbals your loved one takes

Write down the names of any vitamins, supplements, and herbals that your loved one is taking and the health condition for which they were prescribed. Sometimes vitamins, supplements, and herbals can interfere with cancer treatment.

Vitamin/ supplement/ herbal	Dosage amount	How/when to take it	Reason for taking it	Prescribing physician
Name	Number of pills, capsules, drops, etc.	How to take medicine and the time(s) to take it	If stopped, provide reason	Name, phone
Description			Recommended by doctor?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Number of pills, capsules, drops, etc.	How to take medicine and the time(s) to take it	If stopped, provide reason	Name, phone
Description			Recommended by doctor?  <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Number of pills, capsules, drops, etc.	How to take medicine and the time(s) to take it	If stopped, provide reason	Name, phone
Description			Recommended by doctor?  <input type="checkbox"/> Yes <input type="checkbox"/> No	





# Medical service cost tracker

Date of service	Type of service (doctor visit, prescription, etc.)	Name of health care provider or pharmacy	Total bill	Total amount you paid out of pocket	Date paid

## 3 quick tips

- 1 Get permission from your loved one to talk with their insurance company on their behalf
- 2 Meet with a hospital social worker or case manager
- 3 Keep track of all out-of-pocket medical expenses



# Resources

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## **American Cancer Society**

Website: [www.cancer.org](http://www.cancer.org)

Phone: 1-800-ACS-2345  
(1-800-227-2345)

## **Friend for Life Cancer Support Network**

Website: [www.friend4life.org](http://www.friend4life.org)

Phone: 1-866-374-3634

## **CancerCare**

Website: [www.cancercare.org](http://www.cancer.org)

Phone: 1-800-813-HOPE  
(1-800-813-4673)

## **National Association for Home Care and Hospice**

Website: [www.nahc.org](http://www.nahc.org)

Phone: 1-202-547-7424

## **Cancer Hope Network**

Website: [www.cancerhopenetwork.org](http://www.cancerhopenetwork.org)

Phone: 1-800-552-4366

## **National Cancer Institute**

Website: [www.cancer.gov](http://www.cancer.gov)

Phone: 1-800-4-CANCER  
(1-800-422-6237)

## **Caregiver Action Network**

Website: [www.caregiveraction.org](http://www.caregiveraction.org)

Phone: 1-855-227-3640

## **National Alliance for Caregiving**

Website: [www.caregiving.org](http://www.caregiving.org)

Phone: 1-202-918-1013

## **Family Caregiver Alliance**

Website: [www.caregiver.org](http://www.caregiver.org)

Phone: 1-800-445-8106

## Other resources

If you're looking for local resources, reach out to your loved one's nurse navigator or the hospital social worker. They can be excellent sources of information about support that may be available.















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