Self-Care Plan

Patient Name: **Date:**

Medications to continue (name, dose, number & timing of tablets/day, take until…):
1.
2.
3.
Other treatments (e.g., counseling, physical therapy):
1.
2.
3.
Personal warning signs:
1.
2.
3.
Things that make me feel better:
1.
2.
3.
Name & contact for:
1. Oncology Provider:
2. Primary Care Provider:
3. Social Worker:
4. Psychiatrist or Psychologist:
5. Other Providers:
Upcoming appointments: