Side Effects

Fill in the appropriate contact information for your treatment team and record any side effects you may be experiencing.

S: Surgery **C:** Chemotherapy **RS:** Reconstructive Surgery **H:** Hormonal **R:** Radiation
B: Biological **M:** Medications **CT:** Complimentary therapy **N:** Nutrition **E:** Exercise

Contact	Name	Phone	Email
Surgeon			
Plastic Surgeon			
Radiologist			
Medical Oncologist			
Nurse Navigator			

Category	Side Effect/ Action Taken	Comments	Date	Time

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