Patient's Name_____

Meeting with _____

Date: _____ _____ _____

Time(s): _____ _____ _____

Issue:

_____

_____

_____

_____

1. Recommended Treatment

2. Effectiveness of Treatment

3. Side Effects

4. Any Weight Gain or Appetite Issues?

5. Recovery Rate in view of _____

6 Are there any diet restrictions during his recovery period and treatment?

7. What if we opt not to have this type of treatment?

8. Next Step?

9.

"Get Ready, Get Set…Cuz"
Beatrice Toney Bailey

10.