

Care Plan Option Preference Report

PATIENT:

NURSE:

DOB:

CONTACT INFO:

ADDRESS:

APPOINTMENT DATE: ____/____/____

APPOINTMENT TIME:

CARE PLAN OPTIONS		
PREFERENCE	Option ____	Option ____
Do Not Prefer	<input type="checkbox"/>	<input type="checkbox"/>
Unsure	<input type="checkbox"/>	<input type="checkbox"/>
Prefer	<input type="checkbox"/>	<input type="checkbox"/>

Care Plan Option 1: Chemotherapy and Immunotherapy

Care Plan Option 2: Immunotherapy

Care Plan Option 3: Chemotherapy

Care Plan Option 4: Targeted Therapy

Care Plan Option 5: Supportive Care

Care Plan Option 6: Clinical Trial

Nurse Comments: