## Physicians/Nurses/Pharmacy

Doctors: ____________________ Endocrinologist

____________________ Endocrinologist

____________________ Neurosurgeon

____________________ Otolaryngologist

____________________ Radiation Oncologist

____________________ Family Doctor

____________________

____________________

____________________

Nurses: Lisa Tramble 473-7409

____________________

____________________

Clinic Coordinator: ____________________

____________________

____________________

____________________

## Treatment

Allergies: ______________________________

______________________________

______________________________

______________________________

Surgeries: ______________________________

______________________________

______________________________

______________________________

Others: ______________________________

______________________________

______________________________

______________________________

______________________________

Pharmacy: ______________________________

______________________________

______________________________

______________________________

## Baseline Tests

| | Date | Result |
|---|---|---|
| ☐ MRI: | ________ | ________ |
| ☐ Visual Field: | ________ | ________ |
| ☐ 2˚OGTT: | ________ | ________ |
| ☐ Echo: | ________ | ________ |
| Repeat | ________ | ________ |
| Repeat | ________ | ________ |
| ☐ Colonoscopy: | ________ | ________ |
| Repeat | ________ | ________ |
| Repeat | ________ | ________ |
| ☐ Gallbladder Ultrasound: | ________ | ________ |
| Repeat | ________ | ________ |
| Repeat | ________ | ________ |
| ☐ Bone Density: | ________ | ________ |
| Repeat | ________ | ________ |
| Repeat | ________ | ________ |
| ☐ Sleep Apnea: | ________ | ________ |
| ☐ Test Dose: | ________ | ________ |
| ☐ BP: | ________ | ________ |
| ☐ Weight: | ________ | ________ |
| ☐ Height: | ________ | ________ |

## Reminders

- Please bring an updated list of medications to every appointment.
- If you are Cortisol deficient, and require Cortef; make sure you have received Adrenal Insufficiency Teaching, and are aware of the importance of wearing a Medical Alert Bracelet.
- Remember to get yearly flu shot and ask about pneumococcal vaccinations.
- If you are taking Synthroid make sure you take your pill first thing in the morning with a sip of water and wait 1 hour before eating your breakfast.
- If you are taking Dostinex/bromocriptine, make sure you take it with a snack

| Medications | Dose | Date |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| Medications | Dose | Date |
| --- | --- | --- |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## 28 DAY CYCLE TREATMENT DATE CALCULATOR
(valid until 2011)

Each column represents a 28 day cycle and can be used to schedule when your next injection is due. Firstly read across from the month to the date of your first injection, dates for subsequent injections will be in the same column. If you have any difficulties, please ask your nurse or doctor for help.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Jan | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| Jan/Feb | 29 | 30 | 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| Feb/Mar | 26 | 27 | 28 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| Mar/Apr | 26 | 27 | 28 | 29 | 30 | 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| Apr/May | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| May/Jun | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| Jun/Jul | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| Jul/Aug | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| Aug/Sep | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Sep/Oct | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Oct/Nov | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 1 | 2 | 3 | 4 |
| Nov/Dec | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 1 | 2 |
| Dec | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| Dec | 31 | | | | | | | | | | | | | | | | | | | | | | | | | | | |

When you reach the bottom of your column, start at the top of the previous column in the same colour, ie. two columns before.

**NOTE TO PATIENT:** Please show this card each time you visit your doctor or nurse. Your can use the calendar to plan when your next injection is due.

| Date of Injection | Dosage (mg) | Administered by | Injection Site | Medications / Comments | Date of Next Visit |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

- All follow-up testing and appointments are very important.
- Please have blood work completed at least 2 weeks before appointment. Failure to complete blood work on time will result in appointment cancellation and a longer wait time to see the Doctor(s).
- Make sure IGF-1 is marked on the bottom of your lab slip.
- If you are taking Cortef make sure you take your dose at 8am before you get your blood work done.

## Lab Results

| Ranges | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | IGF-1 | GH | Prolactin | Cortisol | FT4 | Testo. | Estradiol | LH | FSH | Other |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

## Lab Results

| Ranges | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | IGF-1 | GH | Prolactin | Cortisol | FT4 | Testo. | Estradiol | LH | FSH | Other |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

## Follow-up Plan

**Today's Visit:** ____________________

MRI: ____________________

Visual Field: ____________________

Others: ____________________

____________________

Changes: ________________________________

________________________________

Medication Changes: ________________________________

Notes/Questions: ________________________________

**Next Visit:** ________________________________

☐ MRI ☐ Visual Field ☐ Blood work ☐ Others

- - - - - - - - - - - - - - - - - - - - - - - - -

**Today's Visit:** ____________________

MRI: ____________________

Visual Field: ____________________

Others: ____________________

____________________

Changes: ________________________________

________________________________

Medication Changes: ________________________________

Notes/Questions: ________________________________

**Next Visit:** ________________________________

☐ MRI ☐ Visual Field ☐ Blood work ☐ Others