TIME TO TALK
IMMUNO-ONCOLOGY™

HOPA Hematology/Oncology Pharmacy Association

Bristol-Myers Squibb

CELLULAR THERAPY

TRACKING SHEETS FOR EARLY SIDE EFFECTS

Date of CAR T Therapy: _____

Healthcare Team's Phone Number: _____

While you are receiving CAR T therapy, it's important to track any symptoms and tell your healthcare team before the symptoms become severe or life-threatening. The tracking sheets on the next four pages can be used by you or your caregiver to record your symptoms. (You can print out the tracking sheets and complete them by hand, or download the sheets and complete them on a computer.) The regular recording of symptoms will help your healthcare team identify any side effects of CAR T therapy early.

Notes from Your Healthcare Team About Monitoring and Symptom Tracking

_____

_____

_____

_____

_____

_____

Symptom Tracking for Cytokine Release Syndrome

The symptoms to track for cytokine release syndrome include those that can lead to high fevers and low blood pressure. This tracking sheet will help you keep track of those symptoms. Record your symptoms in the morning and evening by completing **Table 1** below.

Table 1. Symptom Tracking for Cytokine Release Syndrome

Date mo/day/yr	Time	1. Temperature (degrees Fahrenheit)*	2. Blood pressure (mm Hg)** *(if a home monitoring device is available)*	3. Heart rate (or pulse) per minute	4. Breaths per minute	5. Volume of fluids by mouth (in ounces) Goal per day = ____ ounces.	Notes
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						
	__ AM						
	__ PM						

**Contact your healthcare team if you have a temperature of 100.4 °F or higher.*

***Contact your healthcare team if you have a blood pressure reading lower than 90 mm Hg systolic (top number) or 60 mm Hg diastolic (bottom number).*

Symptom Tracking for Neurologic Side Effects (Those Affecting the Brain, Spinal Cord, and Nerves)

Side effects can also develop in the brain, causing confusion, seizures, or headaches. These are called *neurologic toxicities*.

Your caregiver will help you assess for neurologic side effects by asking you to answer the questions and complete the tasks in **Table 2**, parts 1 and 2.

Note to the caregiver: If the patient answers "No" to questions 1–5 or "Yes" to questions 6–11, contact the healthcare team immediately. The patient may be showing early signs of neurologic side effects. Also contact the healthcare team if the patient shows symptoms of a seizure (is confused, seems to be in a trance, has jerky movements, or passes out).

Table 2. Symptom Tracking for Neurologic Side Effects: Part 1

Date mo/day/yr	Time	1. Are you able to name the current month and year?	2. Are you able to name your current location?	3. Are you able to find and point to a specific named object in the room? *(Example: Your caregiver asks you to point to the clock. Can you find and point to the clock?)*	4. Are you able to write your full name on a piece of paper?	5. Are you able to count backward from 100 by 10?	6. Are you having any difficulty finding words or speaking?
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Table 2. Symptom Tracking for Neurologic Side Effects: Part 2

Date mo/day/yr	Time	7. Are you having shaking movements or trembling?	8. Do you have difficulty waking up?	9. Are you more tired than normal?	10. Do you have a headache?	11. Are you feeling restless or anxious?	Notes
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	

Tracking of Other Symptoms

If you are experiencing any other symptoms that you want your provider to be aware of, list them in the first row of **Table 3** and record what time they occur each day.

Table 3. Tracking of Other Symptoms

Date mo/day/yr	Time	Symptom: ____	Symptom: ____	Symptom: ____	Symptom: ____	Notes
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ AM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	
	__ PM	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	