

The Victorian Long Term Follow-Up Program Supporting all children and adolescents with cancer treatment late effects across Victoria

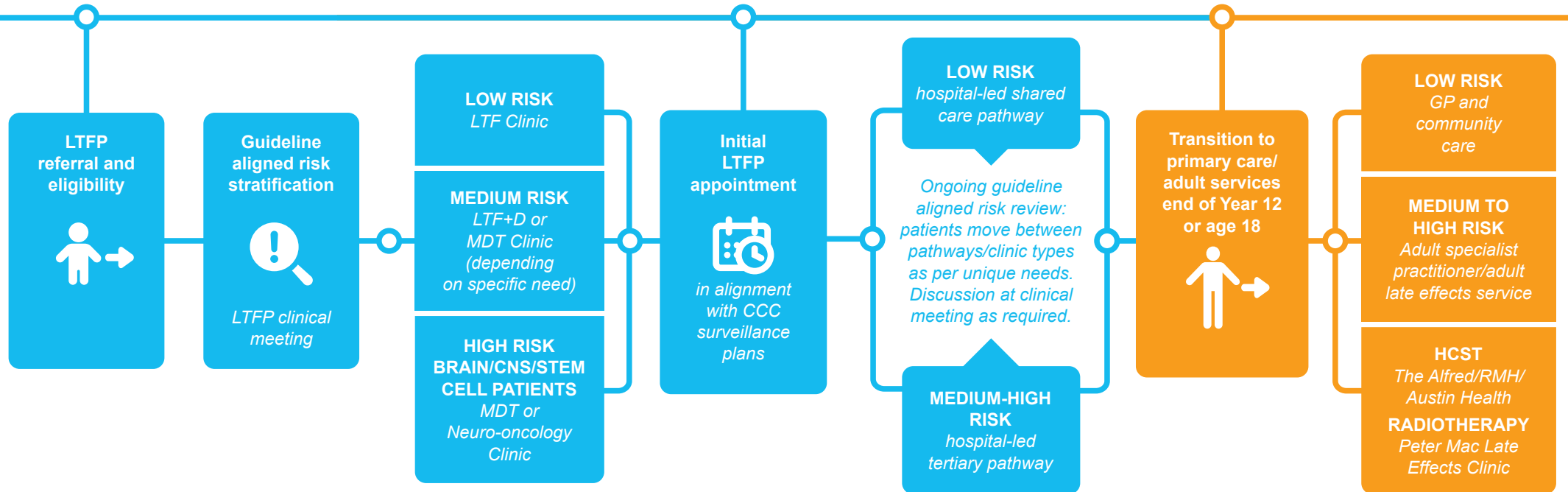
Ongoing CCC cancer surveillance and monitoring up to 3–5 years from completion of treatment

In partnership with primary care and paediatricians, the LTFP provides screening, monitoring and support for late effects of cancer treatment, and monitoring for recurrence of cancer or a new diagnosis. We provide physical and emotional wellbeing assessments, promote healthy lifestyles and empower families to manage future healthcare needs

2 YEARS AFTER COT

WITHIN 3 YEARS OF COT

18 YEARS OLD



REFERRAL AND ELIGIBILITY

- <18
- 2 years post completion of treatment **OR earlier if** Brain/CNS or if MDT input required for high risk late effects
- Referral contains details of ongoing CCC surveillance plan

LTFP CLINICAL MEETING

- Patient discussion throughout LTFP journey as required
- Guideline aligned triage into risk stratified clinic
- Review of prior psychosocial assessment
- Plan in alignment with any ongoing CCC surveillance monitoring and investigations
- Red flags for endocrinology and fertility involvement
- Transition discussion if appropriate

REVIEW AND ASSESSMENT

- Guideline aligned physical examination, screening and assessment in risk stratified clinic
- Referrals
- Test/investigations
- Signposting to support services
- Ongoing pathway explained
- Shared-care discussed and expectations managed

SHARED CARE

- For appropriate families – partnerships with metro and regional GPs and Paediatricians (as per agreed Roadmap) to provide:
 - Guideline aligned physical examination, screening and assessment
 - Referrals
 - Test/investigations
 - Resources and links to local supports

DOCUMENTATION AND RESOURCES

- Treatment Summary
- Personalised surveillance 'Roadmap'
- Consent form for registry
- Registration to online portal
- Age and stage appropriate education and support resources
- Annual pre-clinic questionnaire

TRANSITION

- 13+ offer time alone clinics
- 15+ transition introduced
- 16+ transition plan in place. If transitioning to GP ensure established relationship with GP
- Transition education and resources provided
- Transition at end of Year 12 or age 18

If 14+ at diagnosis, support with transition planning including Treatment Summary, surveillance 'Roadmap' and access to resources. Patients can be discussed in LTFP clinical meeting if required.