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| Name:  Address:  DOB:  HCRN:  Consultant:  Ward: |

**Assessment-Baseline[[1]](#footnote-1)**

Assessment date/time\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

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| **Patient details** | |
| Patient preferred name:  Patient contact number: | Name of Next of Kin:  Relationship:  Contact number: |
| Pharmacy:  Contact number:  Fax number: | GP:  Address:  Contact number :  Fax number: |
| Public/Private Medical Card Yes🞏 No🞏  Insurance company name:  Medical card number: | **Allergies/ sensitivities:** |
| **Any patient infection control alert/issues or recent hospital admissions? Yes🞏 No🞏**  **If yes, has patient had appropriate infection control screening? Yes🞏 No🞏**  Date of last screen:  Result of last screen: | |

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| **Confirmed Treatment Plan** | | |
| Diagnosis: | TNM Stage: | ECOG Status[[2]](#footnote-2): |
| Name of regimen: | Number of planned cycles: | Frequency of cycles: |
| Treatment intent :  Adjuvant🞏  Neo-Adjuvant🞏  Metastatic🞏  Palliative/supportive care🞏 | Clinical Trial patient🞏  Trial name:  Trial nurse: | Height:  Weight:  Checked and verified by |
| G-CSF prophylaxis Yes🞏 No🞏 Type used: Frequency: | | |
| Radiotherapy Yes🞏 No🞏 Start date: End date: | | |
| Take home prescription given including high-tech script? Yes🞏 No🞏 NA🞏  List of take home medication prescribed to patient: | | |
| Treatment Start date given Yes🞏 No🞏 Date: Time: | | |
| Appointment booked Yes🞏 No🞏 SACT script complete Yes🞏 No🞏 | | |
| SACT prescription sent to pharmacy Yes🞏 No🞏 NA🞏 | | |

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| **Social Assessment** | |
| Occupation |  |
| Name of the person the patient lives with |  |
| Accommodation | Type of accommodation: Two story House🞏 Bungalow🞏 Nursing home🞏 Sheltered accommodation/No fixed abode🞏 Other🞏 Details: |
| Support/care services involved | Is there anyone dependent or reliant upon the patient? Yes🞏 No🞏 Details |
| Meals on wheels\_\_\_\_\_\_\_days per week |
| Home help : \_\_\_\_\_\_\_\_\_\_\_hours per day/week |
| Hospice and palliative home care involvement? Yes🞏 No🞏 Details |
| Public Health Nurse:  Health centre:  Contact number:  Fax number  Community services: |
| Special needs/disabilities | Interpreter required: Yes🞏 No🞏  Language: |
| Disabilities: Hearing🞏 Sight🞏 Mobility🞏 Learning🞏 Other🞏  Details |
| Alcohol/Tobacco use | Alcohol use: Yes🞏 No🞏 Units weekly: |
| Ex tobacco user: Yes🞏 No🞏  Current tobacco use: Yes🞏 No🞏 Daily usage:  Is this patient interested in quitting smoking? Yes🞏 No🞏 NA🞏  Advise to contact their GP or HSE quit team Yes🞏 No🞏 NA🞏 |
| Other substances |
| Financial | Income concerns |
| Notes: | |
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| **Baseline Vital Signs** (as applicable) | | | | |
| Blood pressure | Pulse | Respirations | SpO2 | Temperature |
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| **Current Medications** | | | | | | |
| Medication | Dose | Frequency |  | Medication | Dose | Frequency |
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| **Relevant Medical and Surgical History** |
| **Include prior cancer treatment: e.g. surgery, radiotherapy, hormonal and biological therapy** |
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| **Relevant Family History** |
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| **Patient ADLS Assessment[[3]](#footnote-3)** | | |
| **Activity** | **Tick if no Issues** | **Comments** |
| Communication |  |  |
| Breathing/Circulation |  |  |
| Eating and Drinking |  | Document weight loss or use MUST score using appendix 3 |
| Elimination |  |  |
| Washing & Dressing |  |  |
| Mobility |  |  |
| Sleeping |  |  |
| Dying/Spirituality |  |  |
| Pain |  |  |
| Maintaining a Safe Environment |  |  |
| Expressing Sexuality |  |  |
| Controlling Body Temperature |  |  |

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| **Oral Health** |
| Current dental routine: |
| **Dentures**  Does patient wear dentures Yes🞏 No🞏 Do they fit well? Yes🞏 No🞏  Details: |
| **Pre Existing Problems and Risk Factors**  Signs of fungal infection🞏 Herpes infection🞏 Mouth pain🞏 Dry mouth🞏 Elderly🞏 Endotracheal intubation🞏 Head & neck cancer🞏 Previous history of oral mucositis🞏  Heart Disease🞏  **Other:** |
| Is the patient for biphosphonates Yes🞏 No🞏 Details: |
| See appendix 2. and use the Oral Assessment Guide (OAG)[[4]](#footnote-4) to allocate a score to the patient: |
| Does patient require a dental review prior to treatment Yes🞏 No🞏 Reason: |

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| **Skin** |
| Include details of general skin condition, wounds, drains, existing rashes etc |
| **No skin related Issues 🞏** |
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| **Fertility** |
| Use of contraception discussed Yes🞏 No🞏 |
| If applicable, does the patient wish to discuss fertility preservation? Yes🞏 No🞏 NA🞏 |
| Has the patient any existing fertility issues/concerns? Yes🞏 No🞏 Details: |
| Fertility clinic referrals sent Yes🞏 No🞏 Date:  Virology bloods taken for the National Virus Reference Laboratory? Yes🞏 No🞏  Patient given written information on egg/embryo freezing/ sperm banking? Yes🞏 No🞏 |
| **Information given** |
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| **Venous Access Assessment** |
| **Is a CVAD indicated for any of the following reasons**:  Drug requirement🞏 Poor peripheral venous access🞏 Needle phobia🞏 Lymphodema🞏  Bilateral mastectomy🞏 **Other:** |
| **Type of CVAD** |
| PICC🞏 Portocath🞏 Hickman🞏 Other: |
| **Line Insertion Organisation** |
| Insertion appointment booked Yes🞏 No🞏 NA🞏 Date: Time:  Pre insertion bloods ordered/taken Yes🞏 No🞏 NA🞏  Advised to fast from X am morning of insertion Yes🞏 No🞏 NA🞏    Coagulation issues **Details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Actions taken and advice given:  Consent form signed Yes🞏 No🞏 NA🞏  Are any investigations required pre insertion? Yes🞏 No🞏 NA🞏  Are investigations booked? Yes🞏 No🞏 **Details:** |

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| **Pre treatment Investigations**  **(e.g. CT,MRI,PET,CXR, ECG, ECHO, MUGA SCAN, cardiac MR, PFTs, Audiogram )** | | | |
| **Type of investigation** | **Request sent?**  Yes No | | **Comments including frequency required** |
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| **Pre Chemotherapy Bloods and urinalysis** |
| Bloods taken🞏 Bloods ordered🞏  FBC🞏 U&E🞏 LFTs🞏 Bone profile🞏 Coagulation screen🞏 Iron studies🞏 TFTs🞏 CRP 🞏 Other🞏:  Tumour markers🞏 Details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Urinalysis taken Yes🞏 No🞏 NA🞏 Results:  Sample sent to lab: Yes🞏 No🞏 NA🞏 |

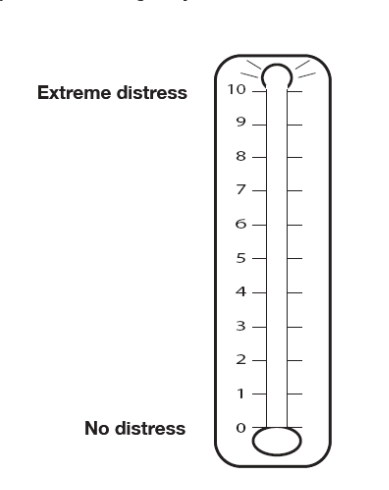
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| **Multidisciplinary Team (MDT) referrals made** | | | | |
| **Disciplines** | **Yes** | **No** | **NA** | **Comments** |
| Medical Social Worker |  |  |  |  |
| Dietician |  |  |  |  |
| Physiotherapy |  |  |  |  |
| Speech and Language |  |  |  |  |
| Occupational therapy |  |  |  |  |
| Psycho-oncology/  Psychology |  |  |  |  |
| Palliative care |  |  |  |  |
| CNS Referral  (state discipline) |  |  |  |  |
| Public health nurse |  |  |  |  |
| Community Intervention team (CIT) |  |  |  |  |
| Hair piece referral |  |  |  |  |
| ICS care to drive |  |  |  |  |
| Smoking cessation |  |  |  |  |
| **Other** | | | | |
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| **Education Record** | | | | | |
| * Education provided by: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Role:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ * Has the patient received any education from the Irish Cancer Society or other support organisation Yes🞏 No🞏 * Education provided to: Patient🞏 Family member🞏 Friend🞏 Care provider🞏   Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   * Teaching aids used: Verbal🞏 Written🞏 Demonstration🞏 * Emergency contact details given Yes🞏 No🞏 * Has alert card been issued Yes🞏 No🞏 NA🞏 | | | | | |
| **Topics** | **Education Given?** | | | | **Comments** |
| Yes | | No | N/A |
| Alopecia/hair thinning |  | |  |  |  |
| Anaemia |  | |  |  |  |
| Cardiac toxicity |  | |  |  |  |
| Constipation |  | |  |  |  |
| Diarrhoea |  | |  |  |  |
| Fatigue |  | |  |  |  |
| Hand/foot syndrome |  | |  |  |  |
| Hypersensitivity reactions |  | |  |  |  |
| Infection |  | |  |  |  |
| Mood changes |  | |  |  |  |
| Nail changes |  | |  |  |  |
| Nausea & vomiting |  | |  |  |  |
| Mucositis |  | |  |  |  |
| Ototoxicity |  | |  |  |  |
| Peripheral neuropathy |  | |  |  |  |
| Safe handling of cytotoxic drugs |  | |  |  |  |
| Scalp cooling |  | |  |  |  |
| Skin Reactions |  | |  |  |  |
| Other | | | | | |
| Consent process | |  |  |  |  |
| Oral chemotherapy self administration | |  |  |  |  |
| CVAD insertion | |  |  |  |  |
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| **Literature given:**  Chemotherapy booklet🞏 Neutropenia booklet🞏 Mouth care leaflet🞏 Supportive services🞏  Day unit leaflet🞏 **(can be change based on what’s available locally)**  **Other:** | | | | | |

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| **Assessment of patient understanding of treatment** | | | | |
| Question | Yes | No | NA | Comments |
| Is patient aware of extent of disease? |  |  |  |  |
| Is patient aware of the goals of treatment? |  |  |  |  |
| Can the patient verbalise their understanding of the treatment regimen and treatment process? |  |  |  |  |
| Does the patient know how response will be measured? |  |  |  |  |
| Does the patient understand their treatment options? i.e. chemotherapy verse best supportive care |  |  |  |  |
| Is the patient aware they have the right to refuse or stop treatment at any time? |  |  |  |  |
| Does the patient understand that there may be a need for the use of blood products or other supportive interventions during the course of their treatment? |  |  |  |  |

**Distress Thermometer[[5]](#footnote-5)**

1. Please circle the number below (0-10) that best describes in general how much distress you have been experiencing over the past week, including today.
2. If any of the items below have been a cause of distress over the past week, please tick the box next to it. Please leave it blank if it does not apply to you
3. Then rank (1st, 2nd,3rd, 4th) your top 4 concerns (1 would be your biggest concern and 4 would be your 4th biggest concern) and put this number beside the item in the ranking column



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| Rank | **Practical concerns** | Rank | **Spiritual/religious concerns** |
|  | Caring responsibilities |  | Loss of faith or other spiritual concerns |
|  | Housing or finance |  | Loss of meaning or purpose in life |
|  | Transport or parking |  | Feeling regret about the past |
|  | Work or education |  | **Physical concerns** |
|  | **Family concerns** |  | My appearance |
|  | Relationship with my children |  | Bathing or Dressing |
|  | Relationship with my partner |  | Passing urine |
|  | Relationship with relatives/friends |  | Changes in appetite |
|  | **Emotional concerns** |  | Problems speaking or using my voice |
|  | Loneliness/isolation |  | Feeling bloated |
|  | Sadness |  | Getting around |
|  | Depression |  | Indigestion |
|  | Worry, fear, anxiety |  | Dry, itchy, sore skin |
|  | Anger or frustration |  | Sleep problems |
|  | Guilt |  | Hot flushes |
|  | Hopelessness |  | Memory or concentration |
|  | Difficulty making plans |  | Wound care after surgery |
|  | Sexual concerns |  | Other medical conditions or disabilities |
| **Other concerns:** | | | |

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| **Note and actions taken:** Psychological history/cognitive status/current mood/ reaction to Diagnosis |
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Assessment completed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NMBI pin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Date/Time** | **Nursing Notes** | **Initials/NMBI pin** |
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| **Signature Bank** | | | | |
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**Appendix 1: ECOG Status**

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| **ECOG Status** | | | | |
| **ECOG score 0** | **ECOG score 1** | **ECOG score 2** | **ECOG score 3** | **ECOG score 4** |
| Fully active, able to carry on all pre-disease performance without restriction | Restricted in physically strenuous activity but ambulatory and able to carry out work of light or sedentary nature, e.g. light house work, office work | Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% or waking hours | Capable of only limited self care, confined to bed or chair more than 50% of waking hours | Completely disabled, cannot carry on any self- care. Totally confined to bed or chair |

Oken M, Creech R, Tormey D, et al. Toxicity and response criteria of the Eastern Cooperative Oncology Group.Am J Clin Oncol. 1982;5:649-655.

**Appendix 2: Oral Assessment Guide (OAG)**

When the scores of the eight categories are summed, a normal mouth will receive a score of 8

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| **Oral Assessment Guide (OAG)** Eilers et al 1988 | | | |
| **Category** | **Rating 1** | **Rating 2** | **Rating 3** |
| **Voice** | Normal | Deeper or raspy | Difficulty talking or crying, or painful |
| **Swallow** | Normal swallow | Some pain on swallowing | Unable to swallow |
| **Lips** | Smooth, pink and moist | Dry or cracked | Ulcerated or bleeding |
| **Saliva** | Watery | Thick or ropey | Absent |
| **Tongue** | Pink, moist and papillae present | Coated, loss of papillae with a shiny appearance with or without redness.  Fungal infection | Blistered or cracked |
| **Mucous membranes** | Pink and moist | Reddened or coated without ulceration or fungal infection | Ulceration with or without bleeding |
| **Gingiva** | Pink and firm | Oedematous with or without redness. | Spontaneous bleeding or bleeding with pressure |
| **Teeth (if none, score 1)** | Clean and no debris | Plaque or debris in localized areas (between teeth) | Plaque or debris generalized along gum line |

Eilers J, Berger AM, Petersen MC. Development, testing, and application of the oral assessment guide (OAG). *Oncology Nursing Forum*. 1988 May-Jun;15(3):325-30

**Appendix 3: Malnutrition Universal Screening Tool (MUST)**

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| **Malnutrition Universal Screening Tool** | | |
| **Step 1:** BMI score | **Step 2:** Weight loss score | **Step 3:** Acute disease effect score |
| BMI kg/m2 score | Unplanned weight loss in past 3-6 months | If the patient is acutely ill **AND** there has been or is likely to be no nutritional intake for >5 days |
| >20 = 0 | <5% = 0 |  |
| 18.5 - 20 = 1 | 5-10% = 1 | Score = 2 |
| <18.5 = 2 | >10% = 2 |  |
| **Score 0 = Low risk Score 1 = Medium risk Score 2 or more = High risk** | | |

The British Association of Parenteral and Enteral Nutrition (BAPEN). Malnutrition Universal Screening Tool. Redding, CA: BAPEN, 2003

1. This assessment can also be used for a patient commencing oral anti cancer agents [↑](#footnote-ref-1)
2. See appendix 1 ECOG status [↑](#footnote-ref-2)
3. Roper, Logan and Tierney Model of Nursing [↑](#footnote-ref-3)
4. Please see appendix 2: Oral Assessment Guide (OAG) Eilers et al 1988 [↑](#footnote-ref-4)
5. Adapted from the National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for Distress Management, Distress Thermometer V 2. 2016 [↑](#footnote-ref-5)