



DT9188

User's family name and given name		
Date of birth (Y, M, D)	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Address (number, street)		
City		Postal code
Health insurance number		File number

INITIAL ASSESSMENT OF CANCEROLOGY PATIENT

Telephone interview Telehealth interview In person interview

Email address _____

1. GENERAL INFORMATION

Diagnosis

Date of diagnosis Year Month Day TNM/stage Age ♀ ♂

Treatment plan

Intent: Curative Palliative

Central venous catheter Catheter type Location of catheter Date placed Year Month Day

Allergies: Yes No Intolerances If yes, product(s) and reaction(s)

2. PARTNERS

Professional	Name	Location	Area code	Phone
Physician				
Treating physician(s)				
Community pharmacy				
Other health care professionals				

3. CONTACT PERSONS

Name	Relation	Area code	Main phone

4. CURRENT ILLNESS HISTORY, COMORBIDITIES AND PAST MEDICAL HISTORY

History of current illness

Diabetes: Type 1 Type 2 Treatment: Diet only Oral hypoglycemics Insulin therapy

Cardiovascular disease: Anticoagulation therapy: Pacemaker: Yes No

Psychiatric illness Date of diagnosis Year Month Day

Previous surgical procedures / Past medical history and comorbidities (HBP, dyslipidemia)

Patient's name

File number

5. CURRENT MEDICATIONS (including over-the-counter medications, natural products, supplements, etc.)

Insurance: RAMQ Private: Pharmacological profile attached

Vaccination:

6. COMPLEMENTARY AND ALTERNATIVE MEDICINE

7. FUNCTIONAL AUTONOMY – ADL & IADL

0 = Not assessed 1 = Independent 2 = Requires help 3 = Dependent

Activity	0	1	2	3	Assessment of current independence (add explanatory notes if necessary)
Taking medications					<input type="checkbox"/> Dosette Prepared by: <input type="radio"/> Patient <input type="radio"/> Family <input type="radio"/> Pharmacy
Bathing and dressing					
Toileting					
Mobilizing & transferring					<input type="checkbox"/> Accessories used: <input type="checkbox"/> Elevator access Have you had a fall in the past year? <input type="radio"/> Yes <input type="radio"/> No
Climbing stairs					Number of steps: <input type="checkbox"/> Elevator access
Eating					
Cooking					
Housework					
Driving					<input type="checkbox"/> Mode of transportation:
Running errands					

ECOG : _____

8. ASSESSMENT OF SIGNS AND SYMPTOMS (PQRSTU) AND OTHER PARTICULARITIES

Respiratory

Problem: Yes No

Dyspnea: With effort At rest Cough _____ Expectoration _____ Hemoptysis _____

Other: _____

Additional notes on problems detected

Neurovascular

Problem: Yes No

Edema Vascular disease Motor weakness Neuropathy Headaches Drowsiness

Additional notes on problems detected

Pain

Problem: Yes No

Assessment: PQRSTU/previous experiences

Nutrition

Problem: Yes No

Weight: _____ kg Gain Loss Actual Reported by patient Height: _____ cm Actual Reported by patient

Additional notes (weight loss, stable since, etc.)

Denture: Upper Lower Date of last dental exam Year Month Day

Appetite: Increased Reduced Stable No change

Special diet: _____ Dietary supp.: _____

Heartburn Dysgeusia Dysphagia Nausea Odynophagia Pyrosis Stomatitis Vomiting

Other: _____

Patient's name

File number

8. ASSESSMENT OF SIGNS AND SYMPTOMS (PQRSTU) AND OTHER PARTICULARITIES (cont.)**Elimination**Problem: Yes NoIncontinence: Urinary: Occasional Regular Fecal: Occasional Regular Hematuria Dysuria Diarrhea times/day: _____ Constipation Hemorrhoids Rectal bleeding Ostomy (independent): Yes No Stoma and peristomal skin care Cleaning and changing of ostomy pouch Other:**Reproduction/sexuality**Problem: Yes No Andropause/Menopause Hormone replacement therapy Type: _____ Contraception Contraceptive method: _____

Date of last menstruation

Year

Month

Day

 Wants children Hot flashes Night sweats Concerns related to sexuality:**Senses**Problem: Yes No Change in hearing: Tinnitus Deafness Other: _____ Wears hearing aid: Left Right Change in vision: Wears glasses Wears contacts Skin alteration (if applicable, describe skin alteration in the "Additional notes on problems detected" section)

Additional notes on problems detected

Cognitive statusProblem: Yes No Memory loss Decreased attention span Reduced concentration Speech impairment Difficulty with comprehension Known cognitive impairment: _____ Disorientation: Person: _____ Place: _____ Time: _____

Additional notes on problems detected

Well-beingProblem: Yes No Fatigue Anxiety Sleep disturbances Mood and affect: _____

Sleep habits:

Additional notes:

 Suicidal ideation

Suicide risk assessment:

Screening for distress Refer to distress screening tool DTS ___ / 10Problem type: Spiritual Social/family Emotional Practical Physical Information**Substance use**Problem: Yes No Smoking Vaping Number of cigarettes per day _____ Started (year, month) _____ Quit (year, month) _____ Wants to quit Alcohol Weekly consumption _____ Started (year, month) _____ Quit (year, month) _____ Wants to quit Drugs, type(s): _____ Weekly consumption _____ Started (year, month) _____ Quit (year, month) _____ Wants to quit Withdrawal symptoms Onset (year, month, day) _____ : _____**Physical exam**Problem: Yes No

Patient's name

File number

9. KNOWLEDGE AND UNDERSTANDING OF CURRENT ILLNESS

Patient












Family




10. FAMILY SYSTEMS ASSESSMENT

10.1 Assessment of internal structure

Genogram

Ecomap

Household 	Case discussed 	Death 	Marriage/ common-law union 	Separation 	Divorce 	Man 	Woman 	Abortion 	Twin children 	Adoption 
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Strength of relationship based on number of lines (1 to 4)	
Tenuous relationship	
Strained relationship	

Dynamics of family relationships

10.2 Assessment of external structure

Extended family

Community and social support network

Patient's name

File number

10. FAMILY SYSTEMS ASSESSMENT (cont.)

10.3 Assessment of contextual structure

Patient's occupation		Spouse's occupation	
Age and health status of caregiver			
Ethnicity	Religion	Language spoken	Language barrier
Hobbies/sports			
<input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Residence <input type="checkbox"/> Live alone <input type="checkbox"/> With spouse <input type="checkbox"/> Other: _____			
Description of living environment (name of residence, with or without services)			
Financial concerns			

10.4 Assessment of expressive function

Verbal/non-verbal communication with family and health care team
Perceptions and beliefs about the illness, treatments, health care system, religion, and spirituality
Previous experience(s) with cancer
Fears and concerns
Previous losses and challenging life events
Coping strategies
Sources of stress other than the illness
Stress management
Impact of the illness on work and family life

11. INTERVENTIONS

Teach/provide information

<input type="checkbox"/> Physical activity	<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Precautions	<input type="checkbox"/> Sexuality/fertility
<input type="checkbox"/> Diet	<input type="checkbox"/> Surgery	<input type="checkbox"/> Radiotherapy	<input type="checkbox"/> Targeted therapy
<input type="checkbox"/> Palliative approach	<input type="checkbox"/> Symptom management	<input type="checkbox"/> Community resources	<input type="checkbox"/> Transportation and lodging
<input type="checkbox"/> Self-care	<input type="checkbox"/> Immunotherapy	<input type="checkbox"/> Role of IPO	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Neutropenia	<input type="checkbox"/> Role of interdisciplinary team	
Health promotion (smoking cessation, alcoholism, gambling, other.)		Documents provided	
Other documents provided		<input type="checkbox"/> Oncology passport <input type="checkbox"/> IPO contact information	
		Other information/education	

Patient's name

File number

11. INTERVENTIONS (cont.)

Support

- Active listening/support
- Symptom management
(Refer to assessment findings and additional notes in Section 8)
- Other: _____
- Normalization
- Offering support to family
- Mobilizing family caregiving roles
- Offering commendations of family strengths
- Offering commendations of individual strengths

Coordination

Coordination and continuity of care

Date of presentation at interdisciplinary rounds

Year	Month	Day

Referral(s) to members of the interdisciplinary team

Referral(s) to resources (ex. for smoking cessation or alcohol dependency)

Other

12. ASSESSMENT FINDINGS

Problems

See TNP

13. EXPECTATIONS AND NEEDS OF PATIENT AND FAMILY

14. ADDITIONAL NOTES

Nurse's signature

Date

Initial assessment completed:

Year	Month	Day

Yes No

Nurse's signature

Date

Initial assessment completed:

Year	Month	Day

Yes No