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Santé et Services sociaux Québec

DT9188

INITIAL ASSESSMENT OF CANCEROLOGY PATIENT

☐ Telephone interview ☐ Telehealth interview ☐ In person interview

Email address _____

User's family name and given name		
Date of birth (Y, M, D)	Age	Sex ☐ M ☐ F
Address (number, street)		
City		Postal code
Health insurance number	File number	

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, COMORBIDITITES 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	☐	☐	☐	☐	☐ Dosette Prepared by: ◯ Patient ◯ Family ◯ Pharmacy
Bathing and dressing	☐	☐	☐	☐	
Toileting	☐	☐	☐	☐	
Mobilizing & transferring	☐	☐	☐	☐	☐ Accessories used: Have you had a fall in the past year? ◯ Yes ◯ No
Climbing stairs	☐	☐	☐	☐	Number of steps: ☐ Elevator access
Eating	☐	☐	☐	☐	
Cooking	☐	☐	☐	☐	
Housework	☐	☐	☐	☐	
Driving	☐	☐	☐	☐	☐ 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 ☐ No

Incontinence: ☐ 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 status — Problem: ☐ 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-being — Problem: ☐ 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 ___ / 10

Problem type: ☐ Spiritual ☐ Social/family ☐ Emotional ☐ Pratical ☐ 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

Household	Case discussed	Death	Marriage/ common-law union	Separation	Divorce	Man	Woman	Abortion	Twin children	Adoption
										

Ecomap

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

☐ House ☐ Apartment ☐ Residence ☐ Live alone ☐ With spouse ☐ 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 spiritualllity

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

☐ Physical activity	☐ Chemotherapy	☐ Precautions	☐ Sexuality/fertility
☐ Diet	☐ Surgery	☐ Radiotherapy	☐ Targeted therapy
☐ Palliative approach	☐ Symptom management	☐ Community resources	☐ Transportation and lodging
☐ Self-care	☐ Immunotherapy	☐ Role of IPO	☐ Other: _____
☐ Cancer	☐ Neutropenia	☐ Role of interdisciplinary team	

Health promotion (smoking cessation, alcoholism, gambling, other.)	Documents provided ☐ Oncology passport ☐ IPO contact information

Other documents provided	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)*
- ☐ Normalization
- ☐ Offering support to family
- ☐ Mobilizing family caregiving roles
- ☐ Offering commendations of family strengths
- ☐ Offering commendations of individual strengths
- ☐ Other: _____

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 (Year / Month / Day)	Initial assessment completed:
		☐ Yes ☐ No
Nurse's signature	**Date (Year / Month / Day)**	**Initial assessment completed:**
		☐ Yes ☐ No