

Affix patient label within this box

What matters the MOST to you TODAY?

(Screening for Distress)

Date: _____

Screening completed as part of

- New Patient Consult Navigation RT treatment Clinic Review Pain/Symptom management

Information provided by Patient Family Assisted by family/healthcare team member

Please circle the number that best describes how you feel NOW

Referrals

No pain	0 1 2 3 4 5 6 7 8 9 10	Worst possible pain	<input type="checkbox"/> Dietician <input type="checkbox"/> Home Care <input type="checkbox"/> Pharmacy <input type="checkbox"/> Oxygen Therapy <input type="checkbox"/> Pain Management <input type="checkbox"/> Palliative Care <input type="checkbox"/> Social Work <input type="checkbox"/> Dentist <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Medical Oncology <input type="checkbox"/> Family Dr./NP <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Other: _____
No tiredness (Tiredness = lack of energy)	0 1 2 3 4 5 6 7 8 9 10	Worst possible tiredness	
No drowsiness (Drowsiness = feeling sleepy)	0 1 2 3 4 5 6 7 8 9 10	Worst possible drowsiness	
No nausea	0 1 2 3 4 5 6 7 8 9 10	Worst possible nausea	
No lack of appetite	0 1 2 3 4 5 6 7 8 9 10	Worst possible lack of appetite	
No shortness of breath	0 1 2 3 4 5 6 7 8 9 10	Worst possible shortness of breath	
No depression (Depression = feeling sad)	0 1 2 3 4 5 6 7 8 9 10	Worst possible depression	
No anxiety (Anxiety = feeling nervous)	0 1 2 3 4 5 6 7 8 9 10	Worst possible anxiety	
Best well-being (Well-being = how you feel overall)	0 1 2 3 4 5 6 7 8 9 10	Worst possible well-being	_____

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Check all of the following items that are **CURRENTLY** concerns for you **TODAY**

Emotional <input type="checkbox"/> Fears/Worries <input type="checkbox"/> Sadness <input type="checkbox"/> Frustration/Anger <input type="checkbox"/> Changes in appearance <input type="checkbox"/> Intimacy/Sexuality	Physical <input type="checkbox"/> Concentration/Memory <input type="checkbox"/> Sleep <input type="checkbox"/> Weight <input type="checkbox"/> Fever/Chills <input type="checkbox"/> Bleeding/Bruising <input type="checkbox"/> Cough <input type="checkbox"/> Mouth Sores <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Special diet <input type="checkbox"/> Heartburn/indigestion <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Bladder problem <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches	<input type="checkbox"/> Trouble with everyday activities (ie. bathing, dressing) <input type="checkbox"/> Vision or hearing changes <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Changes to skin/nails <input type="checkbox"/> Lymphedema/swelling <input type="checkbox"/> Sensitivity to cold	Spiritual <input type="checkbox"/> Meaning/Purpose of life <input type="checkbox"/> Faith
Practical <input type="checkbox"/> Work/School <input type="checkbox"/> Finances <input type="checkbox"/> Getting to & from appointments <input type="checkbox"/> Home Care <input type="checkbox"/> Accommodation <input type="checkbox"/> Drug Cost <input type="checkbox"/> Health Insurance	Informational <input type="checkbox"/> Understanding my illness and/or treatment <input type="checkbox"/> Talking with the health care team <input type="checkbox"/> Making treatment decisions/Personal Directive <input type="checkbox"/> Creating an Advance Care Directive <input type="checkbox"/> Knowing about available resources <input type="checkbox"/> Taking medications as prescribed <input type="checkbox"/> Quitting smoking	Social/Family <input type="checkbox"/> Feeling a burden to others <input type="checkbox"/> Worry about family/friends <input type="checkbox"/> Feeling alone <input type="checkbox"/> Support with children/partner	Fall Prevention <input type="checkbox"/> History of previous fall <input type="checkbox"/> Sensory deficits <input type="checkbox"/> Impaired mobility <input type="checkbox"/> Generalized weakness <input type="checkbox"/> Cognitive changes <input type="checkbox"/> Taking diuretics/laxatives/narcotics <input type="checkbox"/> No concern identified

CPC reviewed with patient

Patient's Priority: Please mark patient's top priority with an asterisk (*) from either ESAS or CPC list or Other Priority Concern: _____

Response/Management of distress

- Provided emotional support Provided information/education Medication adjusted Further assessment/testing

Form not completed due to: illness patient declined language barrier literacy vision issues unable to reach other: _____

STAFF Comments:

Form not reviewed with patient: Reason: _____

Reviewed by (Name of Health Care Professional)	Signature (of Health Care Professional)	Date (MM-DD-YYYY)

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Screening for Distress Tool:

We would like to better understand your current physical and emotional well-being so that our team of oncologists, nurses, social workers, radiation therapists and dietitians can work towards addressing any concerns you may have.

On the back side of these instructions is the **Screening for Distress Tool**. You are being asked to complete it while waiting to see your oncologist. This tool has been developed by the Saskatchewan Cancer Agency and includes nationally used screening questions to better help our staff identify issues/concerns you may be having and determine how we can best meet your individual needs.

The first component is the **Edmonton Symptom Assessment System, or ESAS**. You are being asked to circle the number that best **indicates how you are feeling at the present time**, with **0** indicating the best possible feeling, and **10**, the worst.

The second component is the **Canadian Problem Checklist**. You are being asked to tick off each box that reflects **issues or concerns that you have experienced within the last week**, including today.

We invite you to have a family member assist you in the completion of the form and if you need further instructions on how to complete the form, please ask one of our volunteers or staff members to help you. Please give the form to the nurse when she calls you for your appointment.

As with any written documentation in the Cancer Center, your answers are confidential and will be used to provide the best care for you and your family.