CANCER CENTRE OF SOUTHEASTERN ONTARIO AT KINGSTON GENERAL HOSPITAL
a cancer care ontario partner

PRIMARY NURSE
(Medical & Radiation)
PLAN OF CARE/INTERVENTIONS

Date (YY/MM/DD) & Time: ________________________

Addressograph

Page 1 of 1 Plan of Care/Interventions

1. *Coordination: (D=Discussed R=Referral)* N/A ☐

	D	R		D	R
Dietician	☐	☐	Quinte Thousand Island Lodge	☐	☐
CCAC	☐	☐	Enterostomal Therapist	☐	☐
Social Work	☐	☐	Sperm Banking	☐	☐
Canadian Cancer Society	☐	☐	APN Cancer Genetics	☐	☐
Spiritual Care	☐	☐	APN ________________________	☐	☐
Systemic Therapy Clinic	☐	☐	Infection Control	☐	☐
Other: __________________	☐	☐	Other: ________________________	☐	☐

Regional Systemic Therapy Closest Site: _________________ ***Blood work***: ☐ N/A ☐ M.D.S. ☐ Other _________________

2. *Teaching/Information Provided:* *Patient Information Collector Binder*. Yes ☐ No ☐ N/A ☐

Chemotherapy/Biotherapy:

Chemotherapy/Biotherapy: Yes ☐ No ☐ Bloodwork: Yes ☐ No ☐ Handbook and Drug Cards: Yes ☐ No ☐

Bone Marrow Aspirate: Yes ☐ No ☐ Sperm Banking: Yes ☐ No ☐ Ambulatory Infusion Pump: Yes ☐ No ☐

Lumbar Puncture: Yes ☐ No ☐ Other Medications____

Radiotherapy:

Radiotherapy Teaching: Yes ☐ No☐ Handbook given: Yes☐ No☐ CT Contrast: Yes ☐ No ☐

Medications: Yes ☐ No ☐ ____

3. *Responses to Teaching:*

Patient verbalizes basic understanding of treatment schedule ☐ Yes ☐ No ☐ N/A

Patient agrees to read information given and write down questions for next visit to review ☐ Yes ☐ No ☐ N/A

Family member/significant other verbalizes an understanding of treatment plan and side effects ☐ Yes ☐ No ☐ N/A

Barriers to Learning: ☐ Yes ☐ No If Yes, list____

____

4. *Procedures Performed*: ☐ N/A ☐ Blood work ☐ Wound Care ☐ Other ______________________________

Procedures Assisted: ☐ Bone Marrow/Aspirate ☐ Lumbar Puncture ☐ Biopsy Aspirate ☐ PAP ☐ Fiberoptic Scope

Post-procedure Instructions: ☐ Yes ☐ No ☐ N/A

5. *Living Will* (Advanced Directives): Yes ☐ No ☐ N/A ☐ ***Power of Attorney:*** Yes ☐ No ☐ N/A ☐

______________________________ Signature/Designation

______________________________ Print Name/Designation

PRIMARY NURSE
(Medical & Radiation)
INITIAL VISIT ASSESSMENT

Date (YY/MM/DD) & Time: ______________________

Page 1 of 5 Assessment Pages

Addressograph

Instructions: Tic boxes, circle grades, narrative

☐ Ambulatory ☐ Inpatient ____________________

Source of Information: ☐ Patient ☐ Other, State who: ____

In the **last 6 months**, were you in another health care facility (Hospital, Nursing Home, Long Term Care) overnight? ☐ Yes ☐ No. Have you ever had a drug-resistant infection, for example **MRSA** or **VRE**? ☐ Yes ☐ No In the past 2 weeks, were you in contact with a person with **SARS**, quarantined for **SARS**, or in a country affected by **SARS**? ☐ Yes ☐ No

Contacting Patient: Home? ☐Yes ☐ No ☐ N/A Work? ☐ Yes ☐ No ☐ N/A

***Leaving Messages* for Patient:** Home? ☐Yes ☐ No Work? ☐ Yes ☐ No

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Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Common Law ____________________

Housing: ☐ House ☐ Apt. ☐ Retirement Home ☐ Nursing Home ☐ Other ________________________________

***Living With*:** ☐ Parents ☐ Partner ☐ Spouse ☐ Children ☐ Friend ☐ Pets ☐ Other________________________

Children: Number _________ Ages ________________ Childcare Needs: ☐Yes ☐ No ____________________

***Transportation to Appointments Concerns*:** ☐Yes ☐ No____

Lodging Needs If Living Out Of Town And Requiring Daily Treatments: ☐ Yes ☐ No

Do You Understand Written Materials? ☐Yes ☐ No ***Language:*** English ☐ Other ________________________

***Occupation*:** ____

Source of Income: ____

Financial Concerns If Work Is Interrupted: ☐Yes ☐ No ☐ N/A

***Drug Benefits*:** ☐ Yes ☐ No If yes, do you have 100% coverage? ☐Yes ☐ No ☐ Don't know

Veteran: ☐ Yes ☐ No

Living Will* (Advanced Directives):** ☐ Yes ☐ No ***Power of attorney for personal care: ☐ Yes ☐ No

If no, would you like information? ☐ Yes ☐ No

CANCER CENTRE OF SOUTHEASTERN ONTARIO AT KINGSTON GENERAL HOSPITAL

ADDRESSOGRAPH

Age: ______________

Height: ____________cm Weight: __________kg

Vital signs (if required): _____________________

____

What is your understanding of why you are here today? ____

____

Past/Current Medical History and Hospitalization:

☐ See Physician's Notes ☐ Documented on Disease Site Form

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

Are you currently on chemotherapy? ☐ Yes ☐ No

Family History of Cancer: ☐ None ☐ See physician's notes

____

____

Allergies: (e.g. food, drug, latex): ☐ None

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

Medications & Complementary Therapies: (e.g. essiac tea, herbs, vitamins, hormone replacement therapies, oxygen):
☐ None

____________________________ ____________________________ ____________________________

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CANCER CENTRE OF SOUTHEASTERN ONTARIO AT KINGSTON GENERAL HOSPITAL

ADDRESSOGRAPH

Baseline Cancer Related Symptoms

Circle Grade (Definitions on back of page)

Item	Grade	Comments (E.g. duration of symptoms etc.)
Clinical Trial	Y ☐ N ☐	
ECOG Performance Status	0 1 2 3 4	
CONSTITUTIONAL SYMPTOMS:		
FATIGUE	0 1 2 3 4	
FEVER	0 1 2 3 4	Neutropenic ☐ Non Neutropenic ☐
ALOPECIA	0 1 2 -- --	
INSOMNIA	0 1 2 3 --	
PAIN	0 1 2 3 4	
LOCATION OF PAIN		
Gastrointestinal: NAUSEA	0 1 2 3 --	
VOMITING	0 1 2 3 4	
ANOREXIA	0 1 2 3 4	
CONSTIPATION	0 1 2 3 4	
DIARRHEA	0 1 2 3 4	
PROCITIS	0 1 2 3 4	
HEARTBURN (DYSPEPSIA)	0 1 2 3 4	
BOWEL CRAMPING	Y☐ N ☐	
DYSPHAGIA/ESOPHAGITIS	0 1 2 3 4	
MUCOSITIS/STOMATITIS	0 1 2 3 4	
Dermatology/Skin: ITCH	0 1 2 3 --	
RASH (Hand-Foot Skin Reaction)	0 1 2 3 --	
RADIATION SKIN REACTION	0 1 2 3 4	
Pulmonary: DYSPNEA (SOB)	0 1 2 3 4	
HICCOUGHS	0 1 2 3 4	
Gyne/G.U.: CYSTITIS	0 1 2 3 4	
FREQUENCY	0 1 2 3 4	
PREMATURE MENOPAUSE	Y☐ N ☐	
Neuropathies: MOTOR	0 1 2 3 4	
SENSORY	0 1 2 3 4	
Other: COLD INTOLERANCE	Y☐ N ☐	

Additional Notes:

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

Symptom	GRADE 0	GRADE 1	GRADE 2	GRADE 3	GRADE 4
Fatigue	None	Mild fatigue over baseline	Moderate or causing difficulty performing some ADL	Severe fatigue interfering with ADL	Disabling
Fever (In the Absence of Neutropenia)	None	38.0 – 39.0 C	>39.0 – 40.0 C	>40.0C for <24 hrs	>40.0 C for > 24 hrs
Alopecia	Normal	Thinning or Patchy	Complete	----------------------	------------------------
Insomnia	Normal	Occasional difficultly sleeping not interfering with function.	Difficulty sleeping interfering with function but not interfering with ADL	Frequent difficulty sleeping interfering with ADL	Disabling
Pain	None	Mild pain not interfering with function	Moderate pain; pain or analgesics interfering with function, but not ADL	Severe pain; pain or analgesics severely interfering with ADL	Disabling
Nausea	None	Loss of appetite without alteration in eating habits	Oral intake significantly decreased without significant weight loss	Inadequate oral caloric & fluid intake; IV fluids, tube feeds or Total Parental Nutrition indicated > 24 hrs	Life threatening consequences
Vomiting	None	1 episode in 24 hours	2-5 episodes in 24 hours, IV fluids indicate < 24 hours	> 6 episodes in 24 hours; IV fluids or TPN indicate > 24 hours	Life threatening consequences
Anorexia	None	Loss of appetite without alterations in eating habits	Oral intake altered. Without significant weight loss or malnutrition; oral nutritional supplements indicated	Associated with significant weight loss	Life threatening consequences
Constipation	None	Occasional or intermittent symptoms	Persistent symptoms with use of laxatives	Symptoms interfering with ADC	Life threatening consequences e.g. obstruction
Diarrhea	None	Increase of < 4 stools/day; mild increase ostomy output	Increase of 4-6 stools/day IV fluids < 24 hr	Increase of > 7 stools/day	Life threatening consequences
Proctitis	None	Rectal discomfort, intervention not indicated	Symptoms not interfering with ADL; medical intervention required	Stool incontinence interfering with ADL	Life threatening consequences e.g. perforation
Heartburn/Dyspepsia	None	Mild	Moderate	Severe	___________________
Dysphagia/ Esophagitis	None	Symptomatic, able to eat regular diet	Symptomatic and altered eating/swallowing IV fluids > 24 hr	Symptomatic and altered severity eating/swallowing e.g. IV fluids > 24hr	Life threatening consequences e.g. obstruction, perforation
Mucositis/ Stomatitis	None	Erythema of the mucosa	Patchy ulcerations or pseudomembranes	Confluent ulcerations or pseudomembranes; bleeding with minor trauma	Tissue necrosis; significant spontaneous bleeding; life threatening consequences
Itch	None	Mild or localized	Intense or widespread	Intense or widespread and interfering with ADL	___________________
Rash: Hand Foot Skin Reaction	None	Minimal skin changes e.g. erythema without pain	Skin changes e.g. peeling, blisters, bleeding, edema or pain, not interfering with function	Ulcerated dermatitis or skin changes interfering with function	___________________
Radiation Skin Reaction	None	Faint erythema or dry desquamation	Moderate to brisk erythema; patchy moist desquamation, mostly confined to skin folds and creases; moderate edema	Moist desquamation other than skin folds and creases, bleeding induced by minor abrasions	Skin necrosis or ulceration of full thickness dermis; spontaneous bleeding from involved site
Dyspnea (SOB)	Normal	On exertion, able to walk up 1 flight of stairs without stopping	Dyspnea on exertion but unable to walk up 1 flight of stairs	Dyspnea with ADL	Dyspnea at rest or requiring ventilator support
Hiccoughs	None	Symptomatic not requiring intervention	Symptomatic requires intervention	Interfering with sleep or ADL	________________
Cystitis	None	Asymptomatic	Frequent dysuria	IV pain medications	Catastrophic bleeding
Frequency	Normal	Increase in frequency or nocturia up to 2 x normal	Increase >2 x normal but <hourly	Hourly or more with urgency or requiring catheter	______________________
Neuropathy - Motor	Normal	Asymptomatic, weakness on exam only	Symptomatic weakness interfering with function but not interfering with ADL	Weakness interfering with ADL	Life threatening; disabling e.g. paralysis
Neuropathy - Sensory	Normal	Asymptomatic but not interfering with function.	Sensory alteration or paresthesia (including tingling), interfering with function, but not interfering with ADL	Sensory alteration interfering with ADL	Disabling

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ADDRESSOGRAPH

Social:

Smoker: ☐ Yes ☐ No # Years ______ # PPD: ______ Alcohol: ☐ Yes ☐ No # of Drinks Per Day: _______

Recreational Drugs: ☐ Yes ☐ No Type: ______________________________

Integument:

Do you have any bumps, bruises, abrasions or incisions? ☐ No ☐ Yes If yes, describe: ______________________

____

Night sweats: ☐ Yes ☐ No

Nutrition:

Recent weight loss: ☐ No ☐ Yes If yes, ___________ kg. since________________ week(s)/month(s)/year(s).

Recent oral intake decreased: ☐ No ☐ Yes If yes, since_____________________ week(s)/month(s)/year(s).

Do you use a glucometer? ☐ No ☐ Yes If yes, how often? ______________________________

Nutrition supplements: ☐ No ☐ Yes If yes, type and amount of supplement______________________

Dentures: ☐ Yes ☐ No Partials: ☐ Yes ☐ No

Date of last dental assessment:______________________________

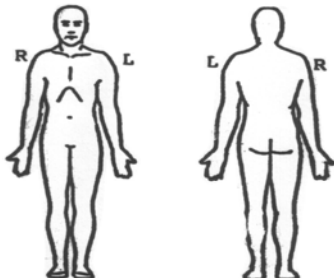
Hearing Aids: Left: ☐ Yes ☐ No Right: ☐ Yes ☐ No Both: ☐ Yes ☐ No Speech problems: ☐ Yes ☐ No

Glasses: ☐Yes ☐ No Eye contacts: ☐ Yes ☐ No

Neurological:

Weakness Affecting ADL: ☐ No ☐ Yes Description: ______________________________

Pain/Discomfort: No Problem ☐ (Location, Quality, Onset, Severity, Radiation and Duration) ________________________



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Palliative Performance Scale (PPSv2)

Version 2

PPS LEVEL	AMBULATION	ACTIVITY & EVIDENCE OF DISEASE	SELF-CARE	INTAKE	CONSCIOUS LEVEL
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable normal job/work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance required	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

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a cancer care ontario partner

ADDRESSOGRAPH

Pain/Discomfort (cont'd):

Measures for pain relief: ____

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Palliative Performance Level: _________________________**%.** (Level definitions on back of page).

Psycho-Social/Emotional/Spiritual:

As well as taking care of your physical health we want to ensure that you're emotional and spiritual well-being are taken care of:

1. How are you and your family coping with the diagnosis?
2. Is there anyone in particular that you are worried about?
3. Has the diagnosis changed? How do you feel about yourself? (Psychologically, physically, etc.)
4. Are you dealing with other stressful life events in your life other than your cancer?
5. Do you have good supports, people that you can talk to, that can help you out if you need it (i.e. extended family, friends, church community)?
6. Would you like to speak to anyone?

Overall Patient's Response To Questions:

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____________________________ ____________________________

Signature/Designation Print Name/Designation