

MULTI-DISCIPLINARY SKIN ASSESSMENT

ADDRESSOGRAPH

Date (YY/MM/DD) & Time: _____ Age: _____ Height: _____ cm Weight: _____ kg

Referred by: _____ Accompanied By: _____

Occupation/Employer: _____ Medications: (list) _____

Drug Coverage: Yes No CCAC _____

Visiting Nurse: Yes No Anticoagulants: Yes No _____

Allergies (list): _____

Current History: Primary lesion: Yes No Recurrent lesion: Yes No Location: _____

How long have you had it? _____ Biopsy: Where: _____ By Whom: _____

Action taken: _____

Past Medical/Family History (Include Surgeries):

Previous lesion(s) treatment: Surgery Radiation Chemotherapy Other _____

Risk Factors:

Sun exposure: Excessive Burns—No Tans Burns—Then Tans Tans Freckles

Hair colour: Blonde Rd Black Brunette

Eye colour: Green/Grey Brown Blue

Other: _____

Assessment for Baselines ECOG/Toxicity Completed: Yes (Back of Page) No

Consult:

Medical Oncology Radiation Oncology Surgery Social Work Dietitian

Other:

Monitor (watch & wait)
 Blood work (Regular basis)
 Other _____

Patient/Family Teaching/Information:

Patient Information Package Skin Care/ Precautions
 OR Package completed Medication
 Contact Numbers Discharge Plan
 Wound Care "Chemo and You" booklet
 Treatment Plan Lodge
 "Radiation and You" booklet

Procedures Performed:

Blood work Wound care Other _____

Procedures Assisted:

Punch Biopsy Core Biopsy FNA Excision of Lesion Excision Biopsy

Treatment:

Biotherapy-High Dose Interferon
 Booking form completed. IV Start date: _____ SC Start date: _____

Chemotherapy
 Booking form completed Start date: _____ Regimen: _____

Radiotherapy Planning Requisition submitted: Yes No

Signature/Designation

Print Name/Designation

Baseline ECOG & Toxicity Assessment (Version 3.0)

Instructions: 1. Tic appropriate modality for symptoms assessed. 2. Circle or tic box as appropriate.	Date (YY/MM/DD): Time:	Additional Comments: (E.g. duration of symptoms etc.)
<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy		
Clinical Trial	Y <input type="checkbox"/> N <input type="checkbox"/>	
ECOG Performance Status	0 1 2 3 4	
Constitutional Symptoms		
Fatigue	0 1 2 3 4	
Fever	0 1 2 3 4 Neutropenic <input type="checkbox"/> Non Neutropenic <input type="checkbox"/>	
Alopecia	0 1 2 -- --	
Insomnia	0 1 2 3 --	
Pain: 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	
Proctitis	0 1 2 3 4	
Heartburn (Dyspepsia)	0 1 2 3 4	
Bowel Cramping	Y <input type="checkbox"/> N <input type="checkbox"/>	
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 <input type="checkbox"/> N <input type="checkbox"/>	
Neuropathies Motor	0 1 2 3 4	
Sensory	0 1 2 3 4	
Other: Cold Intolerance	Y <input type="checkbox"/> N <input type="checkbox"/>	

Signature/Designation

Print Name /Designation