Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

❑ Hôpital du Suroît ❑ Hôpital Anna-Laberge

File # : _____

Name : _____

Date of birth : _____ / ___ / ____ ❑ F ❑ M
year month dayr

Mothers name : _____

MCN : _____

SCREENING OF SYMPTOMS-ONCOLOGY

Date : YYYY-MM-DD Weight : _____kg

Chemotherapy treatment planned on : YYYY-MM-DD

Complete this document **24-48h before** your chemotherapy treatment		
Circle the number that best describes what you have felt or experienced since your last treatment.		
No pain	0 1 2 3 4 5 6 7 8 9 10	Worst possible pain
No tiredness	0 1 2 3 4 5 6 7 8 9 10	Worst possible tiredness
No sleeplessness	0 1 2 3 4 5 6 7 8 9 10	Worst possible sleeplessness
No drowsiness (feeling sleepy)	0 1 2 3 4 5 6 7 8 9 10	Worst possible drowsiness
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 (feeling sad)	0 1 2 3 4 5 6 7 8 9 10	Worst possible depression
No anxiety (feeling nervous)	0 1 2 3 4 5 6 7 8 9 10	Worst possible anxiety
No nausea and/or vomiting	0 1 2 3 4 5 6 7 8 9 10	Worst possible nausea and/or vomiting
No constipation	0 1 2 3 4 5 6 7 8 9 10	Worst possible constipation
No diarrhea	0 1 2 3 4 5 6 7 8 9 10	Worst possible diarrhea
No numbness	0 1 2 3 4 5 6 7 8 9 10	Worst possible numbness
No lesion or pain in the mouth	0 1 2 3 4 5 6 7 8 9 10	Worst possible lesion or pain in the mouth
No redness and itching of the skin	0 1 2 3 4 5 6 7 8 9 10	Worst possible redness and itching of the skin
No urinary problem	0 1 2 3 4 5 6 7 8 9 10	Worst possible urinary problem
Other(s) :		

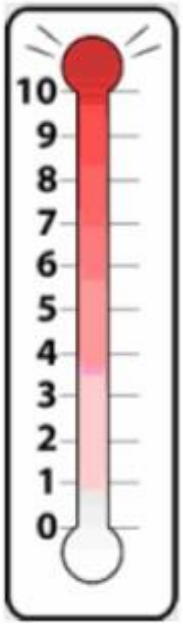
* Adapted from the Échelle d'évaluation des symptômes d'Edmonton révisé (ESAS-R) 2010.

Since your last chemotherapy treatment :

1.	Do you have a fever (≥ 38^{O}C)?	□ Yes	□ No	When :_____
2.	Have you been to the Emergency/hospitalized?	□ Yes	□ No	Date :_____
3.	Are you taking any new medicine?	□ Yes	□ No	Which : _____
4.	Do you have trouble to walk or balance disorder?	□ Yes	□ No	
5.	Have you fallen since your last visit	□ Yes	□ No	
6.	Do you have fear of falling?	□ Yes	□ No	

SCREENING TOOL FOR DISTRESS

Distress is a disagreeable emotion which reduces the quality of life and can interfere with the person's functioning and overall well-being.

Screening for Distress Thermometer	**List of problems**
CIRCLE the number which best describes your situation for the past few days or weeks. 10 = Extreme distress  0 = no distress	Please, **check** all the elements which have been a source of **concern** or a problem for you **over the past few days or weeks.** **Practical difficulties** ☐ Caring for your children ☐ Housing ☐ Insurance/finances ☐ Transport ☐ Work/studies ☐ Decision regarding the treatment plan **Physical difficulties** ☐ Concentration/memory ☐ Self-image ☐ Mobility ☐ Personal hygiene ☐ Sexuality/intimacy ☐ Fertility ☐ Edema (swelling sensation) **Spiritual/religious concerns** ☐ About the meaning of life or my reason for being ☐ Feel shaken in my beliefs **Emotional difficulties** ☐ Fear/worry/nervousness ☐ Sadness ☐ Anger/frustration ☐ Loss of interest in your usual activities **Social/family difficulties** ☐ Relationship with your children ☐ Relationship with your spouse ☐ Relationship with family and friends Other(s) preoccupation(s) : _____ Would you like assistance for any of the problems mentioned above? : ☐ Yes ☐ No

Nurse evaluation notes / analysis / intervention(s) :

_____

_____

_____

_____

_____

_____

_____

Assessment of the nurse:

☐ Patient can receive chemotherapy Signature : _____

Adapted from Screening Tools for Measuring Distress (NCCN, 2013). Comité consultatif sur le volet «Symptômes» du registre de cancer. Direction de la lutte contre le cancer MSSS (2008)