Patient Intake Assessment Tools for Navigation

Review and utilize the following with new patient ***referrals*** to the Navigation program:

- **Psychosocial Distress Screening Tool :** Commission on Cancer Standard 3.2, patients with cancer are offered screening for distress a minimum of 1 time per patient at a pivotal medical visit to be determined by the program.

- **Barriers to Care:** Commission on Cancer Standard 3.1 under Patient Navigation Process, refers to individualized assistance offered to patients, families and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care and can occur from prior to a cancer diagnosis through all phases of the cancer experience. (example tool attached)

- **Intake Patient Assessment Form** (attached)

- **Review of Support Services at Your Cancer Program and Community**

Review the Support Staff and Services Available at Your Cancer Program:

- ☐ Nurse Navigator
- ☐ Social Worker
- ☐ Financial Assistant
- ☐ Registered Dietitian
- ☐ Health Psychologist
- ☐ Genetic Counselor
- ☐ Pastoral Care
- ☐ Health Coaches
- ☐ Survivorship Program
- ☐ Rehabilitation
- ☐ Resource Library
- ☐ Wig Bank
- ☐ Pain and Symptom Management
- ☐ Palliative Care
- ☐ Support Groups
- ☐ Educational programs

Other: _____

Any specific support staff or services needed right now? What can we help you with right now?

_____

_____

Navigation: Patient Intake Assessment Form:
(Use in conjunction with Barriers to Care and Distress Screening Tools)

Name: _____ Date of Birth: _____

Address: _____

Cancer diagnosis: _____

Phone number: (home): _____ (cell):_____

Can we leave a message? Yes ___ No ___

Emergency contact: _____

Phone: (home): _____ (cell): _____

Marital Status: Single ___ Married ___ Significant other ___ Divorced ___ Widowed___

Living Arrangements: Lives Alone ___ with Spouse ___ Significant other ___

Parents ___ Children _____

Caregiver Name:

_____

Phone: (home): _____ (cell): _____

Family and Caregiver concerns:

_____

Children: yes ___ no ___

Concerns with children related to diagnosis, specify;

_____

Religion: _____

Occupation: _____

Preferred Spoken Language: _____

Preferred Written Language Communication: _____

Preferred learning style? i.e. video, written documents, etc. _____

Medical History / Other Medical Conditions:

_____

_____

Surgery: History (list procedure and date):

Procedure	Date

Medications (include name, dose and frequency):

Name	Dose	Frequency

Allergies: _____

Smoking: Yes ___ No ___ Quit (Include Smoking History, ppd/ years): _____

Alcohol Use: Yes ___ How Much (drinks/week) _____

No ___ Quit (Include History, Drinks/week/years) _____

Environmental factors/Occupational exposure: _____

Family History:

Family History of Cancer (list relationship, type of cancer):

Relationship	Type of Cancer

What do you know about your cancer diagnosis?

What has your doctor told you about your cancer diagnosis?

_____

_____

What has your doctor told you about your cancer treatment?

_____

_____

What specific concerns do you have about your diagnosis and treatment?

_____

_____

Do you have an understanding of clinical trials?

_____

_____

Other Physicians involved in your care:

Primary Care Physician: _____

Surgeon: _____

Plastic Surgeon: _____

Medical Oncologist: _____

Radiation Oncologist: _____

Other: _____

Pain and Symptom Management Assessment:

Pain: Scale of 0-10, (10 is the highest, rate you pain level over the last 24 hours)

0 1 2 3 4 5 6 7 8 9 10

Describe Your Pain:

_____

_____

Fatigue: scale of 0 - 10 (10 is the highest, rate your fatigue level over the last 24 hours)

0 1 2 3 4 5 6 7 8 9 10

Describe Your Fatigue:

_____

_____

_____

Other symptoms you would like to discuss?

_____

_____

_____

What are your concerns right now? What are your goals for your care?

_____

_____

_____

_____

_____

What can we help you, your family and/or caregiver with right now?

_____

_____

_____

_____

_____

Barriers to Care:
Please check off any of the following items that you feel could prevent you from getting the care you need

- ☐ Financial concerns
    - ☐ High co-pays with insurance
    - ☐ High co-pays with medication coverage
    - ☐ No medication coverage
    - ☐ Inability to pay bills
- ☐ Transportation concerns
- ☐ Homeless or housing concerns
- ☐ Child/Elder care
- ☐ Interpretation concerns, speaks another language, preferred language; _____
- ☐ Cultural concerns
- ☐ Inability to read or write
- ☐ Fear and fatalism
- ☐ Mistrust of the healthcare system
- ☐ Misconceptions about cancer
- ☐ Lack of knowledge regarding treatment plan
- ☐ Lack of support
- ☐ Pain or symptom management
- ☐ Mental health concerns, specify; _____
- ☐ Physical Disability
    - ☐ Inability to walk
    - ☐ Assistive Devices, please list;

      _____
- ☐ Substance abuse, specify; _____
- ☐ Others;

_____

_____

_____

_____

Patient Education:

Patient Treatment Journal and Educational Materials Provided: Yes ___ No ____
If so what educational materials were provided?

_____

_____

National and Government Oncology Resources for Patients, Families and/or Caregivers, examples:

The Cancer Support Community

The American Cancer Society

The Leukemia and Lymphoma Society

National Cancer Institute

National Comprehensive Cancer Network

Commission on Cancer

Other: _____