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
- Pain and Symptom Management
- Palliative Care
- Support Groups
- Educational programs
- Wig Bank

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):

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Medications (include name, dose and frequency):

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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):

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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 your 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: __________________________