Turning commitment into Action

Delaware Cancer Consortium

Cancer Care Coordination Program

(To be completed by the cancer care coordinator.)

(Addressograph)

Information obtained by: Patient___ Other_____ Race/Ethnicity:_____ Gender: ____

Patient's Name: _____ Date Seen: _____ Date of Referral: _____ Insured: Yes__ or No__

Referring Physician:_____Phone:_____ Fax:_____

Other Physician:_____Phone:_____ Fax:_____

Evaluation/Diagnosis

Chief Complaint:_____

Primary Diagnosis:_____

Secondary Diagnosis:_____

Diagnosis Type: Preliminary____ Definitive____ 2nd Opinion Sought: Yes___ or No___ Visit Type: Initial Evaluation ____ Follow-up Evaluation____

Date of Diagnosis: _____ 2nd Opinion Received: Yes____ or No____

Primary Oncology Center:

Head/Neck	☐	Genitourinary	☐	Rehabilitation	☐	Young Adult Follow-Up	☐	Lymphoma	☐
General Oncology	☐	Colorectal	☐	Neuro Oncology	☐	Genetic Risk Assessment	☐	Gynecological	☐
Thoracic/Esophageal	☐	Hepatobiliary/Pancreas	☐	Pain Consultant	☐	Breast	☐		

Oncology Care Team:

Medical Oncologist	_____	Care Coordinator	_____
Radiation Oncologist	_____	Cancer Research	_____
Surgeon	_____	Dentist	_____
Rehab Medicine Physician	_____	Genetic Counselor	_____
Anesthesiologist	_____	Health Psychologist	_____
Neurosurgeon	_____	Registered Dietitian	_____
Hematologist	_____	Social Worker	_____
Other Specialist	_____	Other Specialist	_____

Oncology Care Lead: Medical Oncologist___ Radiation Oncologist___ Surgeon___ Neurosurgeon___ Rehab Physician___ Hematologist___ Anesthesiologist___

Preferred Learning Style

How do you prefer to learn? Discussion_____ Pictures_____ Reading_____ Demonstration_____ Hearing_____ Other_____

Interdisciplinary Teaching Record

Learning Needs/Outcomes The patient/significant other will verbalize understanding of or demonstrate the following:	Date, Time, Initials, Discipline	Method	Whom Taught	Outcome & Comments	Retaught/Reinforced			
					Date, Time, Initials, Discipline	Method	Whom Taught	Outcome & Comments
Lab Work								
Coping With Side Effects								
Diet/Nutrition								
Pain Mgmt. (Assessment Tool/Route)								
Home Management								
Community Resources								
Weight Management								

Other								

Method, Whom Taught & Outcome Codes	
A = Audiovisual	AK = Applies Knowledge
E = Explanation	SI = States/Identifies
H = Handout	RD = Returns Demonstration
R = Role Play	NL = No Evidence of Learning
D = Demonstration	NR = Needs Review
G = Group Class	DI = Denial/Disinterested
P = Patient	SN = See Nurses/Progress Notes
SO = Significant Other	

Initials	Signature	Disciplines

Promotion of Clinical Trial Participation

- Clinical Trial Candidate: Yes____ or No____ Educational materials provided: Yes____ or No____
- Cancer Program's Participation: Are you currently or have you ever been enrolled in:
  ELCAP *(Early Lung Cancer Action Program)*____ Tissue Procurement____ Other_____
- Current Tissue Procurement Consent: Not Candidate____ Yes____ or No____ Referring Physician Return Date: _____
- Comments for Follow-up: _____
  _____

Nutrition

- During the past 4 weeks, my weight has: decreased____ increased____ not changed____
- Height_____ Current Weight _____ Usual Weight_____ Have you had an unplanned weight loss? Yes____ or No____
- Nutrition Referral Generated to: _____

Psychological Screen

Patient presents as: Oriented_____ Cooperative_____ Uncooperative_____ Confused_____ Depressed_____ Anxious_____ Calm_____
Other_____

How have you been doing emotionally? Do any of these apply: Feeling Depressed_____ Felt Fearful_____ Lost Hope_____ Restless Sleep_____

Social Issues

- Do you have any difficulty obtaining your medicines due to finances? _____
- Transportation difficulty to medical appointments?_____
- Difficulty with cooking or cleaning?_____
- Have you noticed any changes in mood or behavior since being diagnosed? If yes, please describe: _____
  _____
- Inadequate support system of family/friends?_____
- Social Service Referrals Generated to: _____

Religious/Spiritual

- How hopeful are you about the future? not hopeful____ hard to decide____ moderately hopeful____ very hopeful____
- On a scale of 0 – 10 (with 10 being the strongest) to what degree are you struggling with issues related to life and death? 0 1 2 3 4 5 6 7 8 9 10 (circle one)
- Has receiving this diagnosis affected your ability to do things that usually help you spiritually? Yes____ or No____
  If yes, in what ways?_____

Rehabilitation

- Do you use a cane, walker, have difficulty walking or need help caring for yourself? Yes____ or No____
- Do you have any swelling in your arm or leg that occurred after cancer surgery? Yes____ or No____
- Do you have pain? Yes____ or No____ If so, where is your pain?_____
- On a scale of 0 – 10 (with 10 being the most severe) please rate the highest level of pain that you have had in the last 24 hours.
  0 1 2 3 4 5 6 7 8 9 10 (circle one)
- On a scale of 0 – 10 (with 10 being the most severe fatigue) please rate the level of the worst feeling of tiredness you felt in the last 24 hours.

0 1 2 3 4 5 6 7 8 9 10 (circle one)

- Mark if any of the following apply: Age 60 or older____ Live alone____ Other Illness: diabetes____ low vision____ existing or prior neurologic illness____ chronic obstructive pulmonary disorder___ arthritis or joint problems___ cardiac problems____

Additional/Comments

_____

_____

_____

_____

_____

Problem, Plan, Follow-up & Resolution

Problem 1:						
Plan:						
Target Date for Completion:						
Follow-up Notes:						
Effectiveness of Resolution:	Circle One:	1 Poor	2 Below Avg	3 Avg	4 Above Avg	5 Very Good
Identify Specific Enablers:						
Identify Specific Barriers:						
Problem 2:						
Plan:						
Target Date for Completion:						
Follow-up Notes:						
Effectiveness of Resolution:	Circle One:	1 Poor	2 Below Avg	3 Avg	4 Above Avg	5 Very Good
Identify Specific Enablers:						
Identify Specific Barriers:						

Problem 3:						
Plan:						
Target Date for Completion:						
Follow-up Notes:						
Effectiveness of Resolution:	Circle One:	1 Poor	2 Below Avg	3 Avg	4 Above Avg	5 Very Good
Identify Specific Enablers:						
Identify Specific Barriers:						

The above information was reviewed prior to discharge with patient/significant other: Yes _____ No _____

Consent for Patient Information

I consent to and authorize _____hospital to furnish the necessary information to enhance the coordination of my care. I allow all necessary treatments, surgical or laboratory procedures, anesthesia, x-ray exams, tests, drugs and supplies as ordered to be reviewed with any agency that will be involved in my care. The goal is to decrease any/all duplication and to coordinate care across the continuum.

_____ _____
Patient Name/Signature Date

Case Closing

Date Case Closed: _____

Reason Case Closed: _____

_____