Alberta Health Services

Affix patient label within this box

Outpatient Referral from Physician/Nurse Practitioner External to CCI

Department of Symptom Control and Palliative Care

1. Diagnosis
   - Primary _____
   - Metastatic to _____
2. Type of service requested
   - ☐ **Pain and Symptom** *(for patients with **cancer-related symptoms** that are inadequately controlled)*
   - ☐ **Community Liaison** *(for advanced cancer patients who are **near/at the point of discharge** from active treatment and follow-up i.e. "NFR")*
3. Please indicate symptom concerns, if applicable
   - ☐ Pain *(location)* _____
   - ☐ Nausea/vomiting ☐ Constipation ☐ Confusion ☐ Dyspnea
   - ☐ Other *(specify)* _____
4. What treatments are currently being used/planned *(e.g. morphine 10 mg po every 4h around the clock, radiotherapy)?*

   _____

   _____
5. If the patient is in the office, please have him/her **fill out the screening form** (attached).
6. Please check if done:
   - ☐ **Fax** the referral and screening forms to **780-432-8419 and**
   - ☐ **Leave a message** at: **Pain and Symptom 780-432-8350 or Community Liaison 780-432-8887**
7. Does the patient need to be seen the same day *(e.g. for severe symptoms)*?
   - ☐ Yes → **Please have the referring physician/nurse practitioner page the Symptom Control/Palliative Care Physician 780-432-8771**
   - ☐ No

Referring Physician/Nurse Practitioner *(print)*	Signature	Date *(yyyy-Mon-dd)*

Edmonton Symptom Assessment System (revised version) (ESAS-r)

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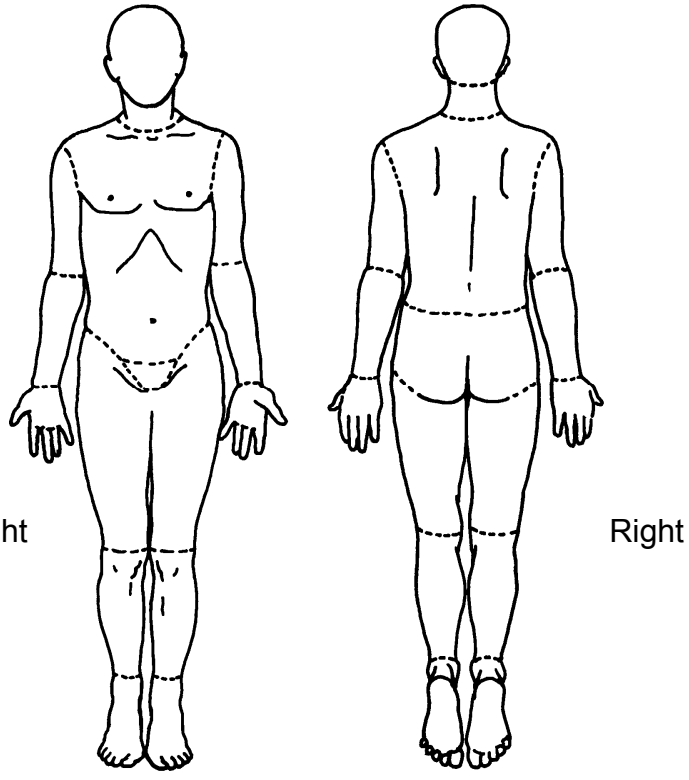
DATE & TIME:

Completed by ☐ Patient ☐ Family caregiver
☐ Healthcare professional caregiver
☐ Caregiver-assisted

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible Pain
No Tiredness (Tiredness = lack of energy)	0	1	2	3	4	5	6	7	8	9	10	Worst possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	0	1	2	3	4	5	6	7	8	9	10	Worst possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst possible Nausea
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 (Depression = feeling sad)	0	1	2	3	4	5	6	7	8	9	10	Worst possible Depression
No Anxiety (Anxiety = feeling nervous)	0	1	2	3	4	5	6	7	8	9	10	Worst possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	0	1	2	3	4	5	6	7	8	9	10	Worst possible Wellbeing
No _____ Other problem (e.g. constipation)	0	1	2	3	4	5	6	7	8	9	10	Worst possible _____

Please mark on these pictures where it is you hurt



Please check all that are applicable:

Is there anything that makes your symptom(s) worse?

☐ Yes *(explain)* _____
☐ No

☐ I need help getting dressed, showered, off the toilet, or moving from one place to another

☐ I have lost weight in the past 3 months

☐ I am experiencing financial difficulties due to my illness

☐ I am interested in receiving spiritual support for myself or my family

☐ I am interested in receiving psychological support for myself or my family

☐ I am being visited at home by a Home Care nurse