Alberta Health Services

Affix patient label within this box

Talking about What Matters to You - Putting Patients First

Your answers will help us understand how you have felt since your last visit, and how you feel today. Knowing this will help us care for you. If you cannot or do not wish to fill out this form for any reason please let us know.

Note: Please make sure to fill out both sides of the form

A member of your healthcare team will go over the form with you and talk to you about what concerns you the most today. If we are not able to talk about all of your concerns today, we will decide the next steps together.

Date *(yyyy-Mon-dd)*	Completed by ☐ Patient ☐ Family ☐ Assisted by family/health professional

Please answer the yes/no questions:

1. Have you been to Emergency and/or been admitted to hospital since your last visit?	☐ Yes	☐ No
2. Have your medications changed since your last visit? *(e.g. stopped, started, dose change)*	☐ Yes	☐ No
3. Have you had a fall since your last visit?	☐ Yes	☐ No
4. Would you like information on Goals of Care or advance care planning *(green sleeve)*?	☐ Yes	☐ No
5. Are you receiving home care services?	☐ Yes	☐ No
6. Have you used tobacco in the past year?	☐ Yes	☐ No
In the past 30 days?	☐ Yes	☐ No

Please **circle** the number that best describes how you feel **now**

0 means you do not have that symptom, 10 means it is at its worst

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 well-being *(Well-being=how you feel overall)*	0 1 2 3 4 5 6 7 8 9 10	Worst possible well-being
No _____ Other problem *(e.g. constipation)*	0 1 2 3 4 5 6 7 8 9 10	Worst possible _____

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What concerns have you had since your **last visit**? Check any boxes that have concerned you.

Emotional
- ☐ Fears/Worries
- ☐ Sadness
- ☐ Frustration/Anger
- ☐ Changes in appearance
- ☐ Intimacy/Sexuality
- ☐ Thoughts of ending my life

Social/Family/Spiritual
- ☐ Feeling alone
- ☐ Feeling like a burden to others
- ☐ Worry about friends/family
- ☐ Support with children/partner
- ☐ Meaning/Purpose of life
- ☐ Faith

Practical
- ☐ Work/School
- ☐ Finances
- ☐ Getting to and from appointments
- ☐ Home Care
- ☐ Accommodation
- ☐ Quitting tobacco
- ☐ Drug costs
- ☐ Health insurance
- ☐ How much alcohol you drink

Physical
- ☐ Fever/Chills
- ☐ Bleeding/Bruising
- ☐ Cough
- ☐ Headaches
- ☐ Concentration/Memory
- ☐ Vision or hearing changes
- ☐ Numbness/Tingling
- ☐ Sensitivity to cold
- ☐ Changes to skin/nails
- ☐ Bladder problems
- ☐ Lymphedema/Swelling
- ☐ Range of motion
- ☐ Strength
- ☐ Speech difficulties
- ☐ Sleep

Mobility
- ☐ Dizziness
- ☐ Walking/Mobility
- ☐ Trouble with daily activities *(e.g. bathing, dressing)*

Nutrition
- ☐ Weight gain (amount) _____
- ☐ Weight loss (amount) _____
- ☐ Special diet _____
- ☐ Difficulty swallowing
- ☐ Mouth sores
- ☐ Taste changes
- ☐ Heartburn/Indigestion
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation

Informational
- ☐ Understanding my illness and/or treatment
- ☐ Talking with my health care team
- ☐ Making treatment decisions
- ☐ Knowing about available resources
- ☐ Taking medications as prescribed

Other concerns:

_____

_____

Thank you for filling out the form. The rest of the form will be completed by your Healthcare Professional.

Health Care Professional Use Only - Screening Intervention Documentation

☐ Patient declined to fill out form ☐ Language barrier ☐ Other _____
☐ Form reviewed through conversation with patient
If form not reviewed indicate reason: ☐ Patient declined discussion ☐ Other _____
Is patient at falls risk? ☐ Yes ☐ No
☐ Patient priority concern identified ☐ Patient indicated no concerns
Specify **one** priority concern *(ESAS-Edmonton Symptom Assessment Scale or CPC-Canadian Problem Checklist)*:

ESAS: ☐ Pain ☐ Drowsiness ☐ Appetite ☐ Depression ☐ Well-being
☐ Tiredness ☐ Nausea ☐ Shortness of breath ☐ Anxiety ☐ Other _____

CPC: ☐ Emotional ☐ Practical ☐ Mobility ☐ Social/Family/Spiritual
☐ Nutrition ☐ Physical ☐ Informational ☐ Other _____

Specific area indicated under CPC domain _____

Actions taken:
☐ Provided information/Education ☐ Offered tobacco cessation advice ☐ Prescription provided
☐ Provided emotional support ☐ Referral suggested but patient declined ☐ No further action

Referrals:
☐ Social Work ☐ Palliative Care ☐ Fatigue ☐ Tobacco Clinic ☐ Dyspnea/Respiratory
☐ Psychology ☐ Nutrition ☐ Home Care ☐ OT/Physio/Speech ☐ CO Navigation
☐ Spiritual Care ☐ Pharmacy ☐ Pain Clinic ☐ Other _____

Further details on action taken:

_____

_____

☐ See progress notes/nursing documentation for further information

Reviewed By *(Name of Health Care Professional)*	Signature *(of Health Care Professional)*	Date *(yyyy-Mon-dd)*