

SUPPORTIVE CARE SCREENING

PATIENT TO COMPLETE

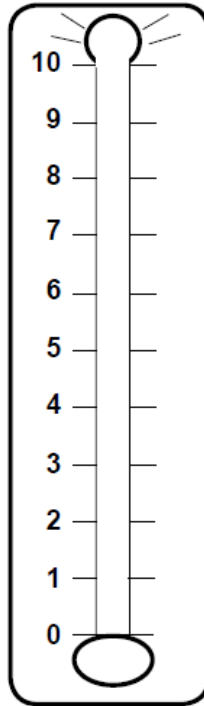
<Insert hospital logo here>

Surname:
 Given Names:
 Date of Birth: Sex:
 UR No:
 (AFFIX PATIENT LABEL HERE)

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

- | YES | NO | <u>Practical Problems</u> | YES | NO | <u>Physical Problems</u> |
|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Child care | <input type="checkbox"/> | <input type="checkbox"/> | Appearance |
| <input type="checkbox"/> | <input type="checkbox"/> | Housing | <input type="checkbox"/> | <input type="checkbox"/> | Bathing/dressing |
| <input type="checkbox"/> | <input type="checkbox"/> | Insurance/financial | <input type="checkbox"/> | <input type="checkbox"/> | Breathing |
| <input type="checkbox"/> | <input type="checkbox"/> | Transportation | <input type="checkbox"/> | <input type="checkbox"/> | Changes in urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Work/school | <input type="checkbox"/> | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | <input type="checkbox"/> | Treatment decisions | <input type="checkbox"/> | <input type="checkbox"/> | Diarrhea |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Eating |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Fatigue |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Feeling swollen |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Family Problems</u> | <input type="checkbox"/> | <input type="checkbox"/> | Fevers |
| <input type="checkbox"/> | <input type="checkbox"/> | Dealing with children | <input type="checkbox"/> | <input type="checkbox"/> | Getting around |
| <input type="checkbox"/> | <input type="checkbox"/> | Dealing with partner | <input type="checkbox"/> | <input type="checkbox"/> | Indigestion |
| <input type="checkbox"/> | <input type="checkbox"/> | Ability to have children | <input type="checkbox"/> | <input type="checkbox"/> | Memory/concentration |
| <input type="checkbox"/> | <input type="checkbox"/> | Family health issues | <input type="checkbox"/> | <input type="checkbox"/> | Mouth sores |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Nose dry/congested |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Pain |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Emotional Problems</u> | <input type="checkbox"/> | <input type="checkbox"/> | Sexual |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | Skin dry/itchy |
| <input type="checkbox"/> | <input type="checkbox"/> | Fears | <input type="checkbox"/> | <input type="checkbox"/> | Sleep |
| <input type="checkbox"/> | <input type="checkbox"/> | Nervousness | <input type="checkbox"/> | <input type="checkbox"/> | Substance abuse |
| <input type="checkbox"/> | <input type="checkbox"/> | Sadness | <input type="checkbox"/> | <input type="checkbox"/> | Tingling in hands/feet |
| <input type="checkbox"/> | <input type="checkbox"/> | Worry | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of interest in usual activities | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <u>Spiritual/religious concerns</u> | | | |

Other Problems: _____

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Which of these are your most *important* concerns right now?

.....

Have you previously had treatment for emotional concerns? Yes No

DATE COMPLETED: ____ / ____ / ____ SIGNATURE: _____

<Insert hospital logo
here>

Kessler Psychological Distress Scale K10

(To only be completed for patients who have a score greater or equal to 4 on the Distress Thermometer above).

For all the questions below please indicate the response which best describes you mood over the past four (4) weeks.

	In the past four (4) weeks	All of the time (5)	Most of the time (4)	Some of the time (3)	A little of the time (2)	None of the time (1)
1	How often did you feel tired out for no good reason?					
2	How often did you feel nervous?					
3	How often did you feel so nervous that nothing could calm you down?					
4	How often did you feel hopeless?					
5	How often did you feel restless or fidgety?					
6	How often did you feel so restless you could not sit still?					
7	How often did you feel depressed?					
8	How often did you feel that everything was an effort?					
9	How often did you feel so sad that nothing could cheer you up?					
10	How often did you feel worthless?					
	TOTAL SCORE					

A score of < 16: indicates persons with no increased likelihood of anxiety or depressive disorder.

A score of 16-30: indicates persons with three times the population risk of having a current anxiety or depressive disorder

A score of 31-50: indicates persons with ten times the population risk of having a current anxiety or depressive disorder

FOR STAFF ONLY

Have you discussed the patient's distress and concerns? Yes No

Referral to GP if K10 ≥ 16 &/or there are issues to be addressed? Yes No

Have any other referrals been made? Yes No

If yes, list which provider(s): _____

Notes: _____

Staff Member:

Ward/Unit:

Screening Offered but declined:

DATE COMPLETED: ____/____/____ **SIGNATURE:** _____