# SUPPORTIVE CARE SCREENING

*PATIENT TO COMPLETE*

<Insert hospital logo here>

Surname: .....

Given Names: .....

Date of Birth: ..... Sex: .....

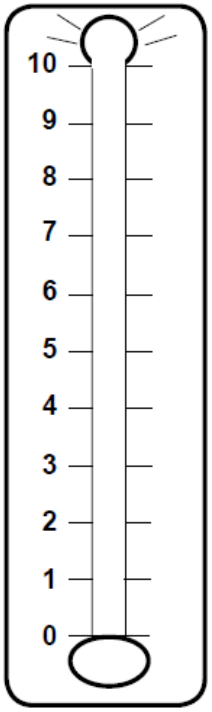
UR No: .....

*(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 | Practical Problems |
|---|---|---|
| ❑ | ❑ | Child care |
| ❑ | ❑ | Housing |
| ❑ | ❑ | Insurance/financial |
| ❑ | ❑ | Transportation |
| ❑ | ❑ | Work/school |
| ❑ | ❑ | Treatment decisions |
| | | **Family Problems** |
| ❑ | ❑ | Dealing with children |
| ❑ | ❑ | Dealing with partner |
| ❑ | ❑ | Ability to have children |
| ❑ | ❑ | Family health issues |
| | | **Emotional Problems** |
| ❑ | ❑ | Depression |
| ❑ | ❑ | Fears |
| ❑ | ❑ | Nervousness |
| ❑ | ❑ | Sadness |
| ❑ | ❑ | Worry |
| ❑ | ❑ | Loss of interest in usual activities |
| ❑ | ❑ | **Spiritual/religious concerns** |

| YES | NO | Physical Problems |
|---|---|---|
| ❑ | ❑ | Appearance |
| ❑ | ❑ | Bathing/dressing |
| ❑ | ❑ | Breathing |
| ❑ | ❑ | Changes in urination |
| ❑ | ❑ | Constipation |
| ❑ | ❑ | Diarrhea |
| ❑ | ❑ | Eating |
| ❑ | ❑ | Fatigue |
| ❑ | ❑ | Feeling swollen |
| ❑ | ❑ | Fevers |
| ❑ | ❑ | Getting around |
| ❑ | ❑ | Indigestion |
| ❑ | ❑ | Memory/concentration |
| ❑ | ❑ | Mouth sores |
| ❑ | ❑ | Nausea |
| ❑ | ❑ | Nose dry/congested |
| ❑ | ❑ | Pain |
| ❑ | ❑ | Sexual |
| ❑ | ❑ | Skin dry/itchy |
| ❑ | ❑ | Sleep |
| ❑ | ❑ | Substance abuse |
| ❑ | ❑ | Tingling in hands/feet |

**Other Problems:** _____

_____



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: _____***