Complete details or affix label

URN: 000 BA3 DOB: 13 / 11 / 51 Gender: M

Surname: Wilson

Given name: William

Radiation Therapy Nursing Assessment

Date: 11/1/13 **Patient Contact Number:** 0400 000 000 **Referred by:** Dr. Lewis

Radiation Oncologist: Dr Costello

Referral to Nurse Care Coordinator (Name/Date): Pat Jones 11/1/13

Diagnosis: SCC Glottis

Clients understanding of reason for treatment: Good; Able to verbalise

Vital Signs

Temp	Pulse	Respiration	Pain Site/Description:	
36.4°C	86	22	Throat	
BP 156/80	**Height** 168cm	**Weight** 85kg	**Pain (0 - 10)** 3/10	**O_2 Sats** 96% roomair

Allergies: Nil Known

History of Present Illness

Diagnosis Date: 10.12.12 **How Diagnosed:** Persistent hoarseness

Previous Treatment	RTX Yes / No	Site Treated: _____ Facility: _____
	Chemo or Targeted Therapy Yes / No	Last Treatment: _____ Medical Oncologist: _____ Facility: _____
	Hormone Therapy Yes / No	Drug name/last treatment: _____ Prescribed by: _____
	Surgery Yes / No	Date/procedure: _____ Facility: _____

Initial Symptoms:	**1. Hoarseness**	**2. Some pain swallowing**	**3. Lump in throat**	**4.**
Current intervention (if any):				
Resolved/Controlled:	**Yes / No**	**Yes / No**	**Yes / No**	**Yes / No**

Concurrent Chemotherapy - Yes / No

Protocol:	**Start Date:**	**Completion Date:**
	Next Cycle Due:	**Facility:**

Pregnancy Status – Is there a possibility that the patient could be pregnant? Yes / No

Past Medical History

Medical	**Surgical**
Cardiac arrhythmia	Pacemaker inserted

Family Cancer History

Nil

Signature: MSloan **Print name:** Maggie Sloan **Designation:** nurse **Date:** 11/1/13

Social History/Habits

Lives with: Alone / Divorced

Other close family/friends:
Daughter and son

Complete details or affix label

URN: 000 BA3 DOB: 13 / 11 /51 Gender: M

Surname: Wilson

Given name: William

Transport to appointments: Walk or Drive

Tobacco – Yes / No Pack/year history 30 Quit ____

Ethanol – Yes / No Units per day/week 14 Quit____

Place of residence during treatment and contact number Main St Motel / 02 99 99 99

Needs assistance with (tick appropriate box)	☐ Activities of Daily Living	☐ Emotional Support	✓ Financial / Legal
	☐ Spiritual Issues	☐ Child Care	✓ Transport
Sleep Disturbance ☐ Yes ✓ No	**If Yes, What Issue?** (tick all appropriate boxes) ☐ Getting to Sleep ☐ Maintaining Sleep ☐ Insomnia ☐ Early morning waking ☐ Sleep apnoea		

Review of Symptoms

Systemic

Fever: Yes / No | Night sweats: Yes / No | Weight loss: Yes / No | Amount lost (kg over time) 2 - 3kg

Fatigue score 0	1 2 3	4 5 6	7 8 9	10
No fatigue	Mild Fatigue	Moderate fatigue	Extreme Fatigue	The worst fatigue

Eyes

Blurred vision		Double vision		Blind		Aids: Yes / No	Glasses / Contact lenses
R	L	R	L	R	L		

Ears, Nose, Mouth, Throat

Hearing loss (tick)		Dental condition			Dentures (tick box)		Dysphagia risk – Yes / No (If Yes - refer to Speech Pathologist)		
R	L	Good	Fair	Poor	Upper	Lower			
Aids: Yes / No		Requires consult: Yes / No			Other:				
R	L	Name of dentist: Dr Thomas							
Tracheostomy: Yes / No					Laryngectomy: Yes / No				

Cardiovascular / Respiratory (circle)

AMI	Angina	Cough	Dyspnoea	O_2 therapy Yes/No	Other:
Stroke	Pacemaker	Haemoptysis		O_2 @ _____L/min	

Gastrointestinal

Nausea	Diarrhoea	Reflux	Ulcers	Other:	Diet - Intake	Diet – Supplements
Vomiting	Constipation	Haemorrhoids			Solid normal/reduced Oral normal/reduced	Yes/No Type:

PEG tube required? Yes / No — Colostomy - Yes / No

Type/Date of insertion: — Ileostomy - Yes / No

Integumentary

Rashes Yes/No Location:	Lesions Yes/No Location:	Oedema Yes/No Location:	Alopecia Yes/No Location:	Healing incision Yes/No Location:

Vascular access : PORT / PICC / CVC
Location:

Date of insertion:
Date flushed:

Other:

Neurological

Orientated (P, P, T) ✓ ✓ ✓	Headache Yes / No	Syncope Yes / No	Depression Yes / No Medication: Managed by:
Memory Good / Fair / Poor	Vertigo Yes / No	Seizures Yes / No Frequency:	Other:

Musculoskeletal

Range of Motion Upper: normal / decreased R/L Lower: normal / decreased R/L	Weakness Upper: normal / decreased R/L Lower: normal / decreased R/L	Balance difficulty Yes / No Falls risk Yes / No (see Falls Risk Assessment)	Mobility aids Yes / No Type:	Assistance with ADLs Yes / No Hygiene / dressing / meals

Genitourinary

Dysuria Yes / No	Frequency Yes/ No	Urinary incontinence Yes / No Type _____	Vaginal itching Yes / No	Vaginal discharge Yes / No
Haematuria Yes/No	Urgency Yes / No			

Signature: MSloan **Print name:** Maggie Sloan **Designation:** nurse **Date:** 11/1/13

Pre – Simulation Information	Complete details or affix label
Pre-medications - Antiemetics _____ Anxiolytics _____	URN: 000 BA3 DOB: 13 / 11 / 51 Gender: M Surname: Wilson
Bowel Prep required - Yes / (No) Full / Empty	
Bladder Prep required - Yes / (No) Full / Empty	Given name: William

FALLS RISK ASSESSMENT

History of falls in last 12 months Yes / (No) Cognitive impairment Yes / (No) Mobility or Transfer Risk Yes / (No)	If yes to any Falls Risk Screen Questions Patient is at Risk of Fall Management Plan implemented Yes / No Management Plan documented Yes / No Referral made to Fall Clinic following consultation with treating team Yes / No

REFERRALS:

Referral to Cancer Nurse Coordinator?	✓ Yes	☐ No	Date referred: 11/1/13
Referral to Dietitian required?	✓ Yes	☐ No	Date referred: 11/1/13
Referral to Social Work required?	✓ Yes	☐ No	Date referred: 11/1/13
Referral to Psychology required?	☐ Yes	☐ No	Date referred:
Referral to Physiotherapy required?	☐ Yes	☐ No	Date referred:
Referral to Occupational Therapy required?	☐ Yes	☐ No	Date referred:
Referral to Speech Pathologist required?	☐ Yes	☐ No	Date referred:
Referral to Pastoral Care required?	☐ Yes	☐ No	Date referred:
Referral to QUIT Coordinator required?	✓ Yes	☐ No	Date referred: 11/1/13

ADDITIONAL INFORMATION / CONCERNS

Pt unable to work during treatment. He will need to have accommodation arranged during the week as he lives 110km away from the treatment centre. Tension between Bill and his daughter obvious. Bill appears angry about diagnosis and being away from home. Discuss with social worker - support for both Bill and his daughter.

Signature: MSloan **Print name:** Maggie Sloan **Designation:** nurse **Date:** 11/1/13

PATIENT MEDICATION SUMMARY

This is a summary document only and is not to be used as a prescription or administration record. It must be completed by a medical officer or pharmacist.

Complete details or affix label

URN: 000 BA3 DOB: 13 / 11 / 51 Gender: M

Surname: Wilson

Given name: William

Allergies: Nil known allergies

Pharmacy: _____ Telephone: _____

CHEMOTHERAPY

NEOADJUVANT (N) CONCURRENT (C)		DRUG	LAST COURSE	FUTURE COURSE(S)	MEDICAL ONCOLOGIST
N	C				
N	C				
N	C				
N	C				

LIST OF CURRENT MEDICATIONS

Date Noted	MEDICATION (Use Generic name)	Documented By	Comments

Signature: Joan Smith **Print name:** Joan Smith **Designation** Clinical pharmacist **Date:** 11/1/13

Date this assessment has been superseded: / / (Complete new assessment form)