



**Remote Symptom Practice Guides
for
Adults on Cancer Treatments**

**Of the Pan-Canadian Oncology Symptom Triage and Remote Support
(COSTaRS) Team**

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Disclaimer

These COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments are intended for use by trained nurses. They provide general guidance on appropriate practice that is informed by a synthesis of evidence (e.g., clinical practice guidelines, systematic reviews) and their use is subject to the nurses' judgment in each patients' individual situation. The COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments are designed to provide information to assist decision-making and are not meant to be prescriptive. Individuals who use these practice guides are required to make their own determination regarding specific safe and appropriate clinical practices. While care has been taken to ensure that these practice guides reflect the state of general knowledge and expert consensus about practice in the field at the date of publication, neither the COSTaRS Steering Committee nor the Canadian Partnership Against Cancer who funded the original project make any warranty or guarantee in respect to any of the content or information contained in these practice guides. Neither group accept responsibility or liability whatsoever for any errors or omissions in these practice guides, regardless of whether those errors or omissions were made negligently or otherwise.

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Overview and Practice Guide Development

Management of cancer treatment-related symptoms is an important safety issue given that symptoms can become life-threatening and often occur when patients are at home. Over 50% of cancer nurses in Canada provide remote support, primarily by telephone.^{1,2} Higher quality telephone services require use of symptom practice guides to minimize risk; however, access to symptom practice guides and their use is variable.^{1,2} With funding from the Canadian Partnership Against Cancer in 2008 we established the pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) research project with representation from eight provinces.

The COSTaRS practice guides were developed using a systematic process guided by CAN-IMPLEMENT[®].^{3,4}

1. We convened a COSTaRS Steering Committee including researchers, an information systems researcher, library scientist, advanced practice nurses, and nurse leaders.
2. For the original project and each update, we conducted a systematic review for *each symptom* to identify clinical practice guideline(s), and if relevant, high quality systematic reviews published in the previous 5 years.
3. We developed 13 symptom practice guides based on the available clinical practice guidelines (median 3 guidelines per practice guide; range 1 to 7). In total, we identified > 40 practice guidelines and appraised their quality using the AGREE instrument (rigor scores range 8% to 87%).⁵ Higher rigour scores indicate higher confidence that potential biases in guideline development were addressed, and recommendations are valid and feasible for practice.⁶ Principles for developing the symptom practice guides included:
 - Using best available evidence.
 - Adding questions from the valid and reliable Edmonton Symptom Assessment System (ESAS) to be consistent with symptom assessment in oncology centres.^{7,8}
 - Using plain language to facilitate use of COSTaRS practice guides in communication between nurses and patients/families (Flesch–Kincaid Grade Level 6.4).
 - Testing the practice guide usability with cancer nurses to ensure they are easy to read; provide just the right amount of information; use appropriate terms; are likely to fit with clinical workflow; and include appropriate self-care strategies.
 - The practice guides were circulated for review and content validation by cancer experts across Canada.
4. In January 2016, the 13 symptom practice guides were updated with evidence from systematic reviews to identify clinical practice guidelines published up to August 2015. New practice guides for pain and sleep changes were added. AGREE Rigour Scores for source guidelines were removed given inconsistent reporting. Evidence ratings were changed to indicate how well the medications work (e.g., effective, likely effective, or expert opinion). The summary of changes for the 2016 update were published.⁹
5. In January 2020, the 15 symptom practice guides were updated and new practice guides for Mouth Dryness/Xerostomia and Skin Rash were added. At the COSTaRS priority setting meeting in 2017, adding evidence for patients receiving Immune Checkpoint Inhibitor therapy into the practice guides was identified as high priority given the increased use of immunotherapy and the special considerations required for managing treatment related symptoms. Key assessment and self-care items for patients receiving immunotherapy were added. End-users asked how severity assessment correlated with the NCI-CTCAE grading that they used in their assessments, clinical documentation and communications with physicians. NCI-CTCAE grading was linked to applicable assessment questions. The summary of changes for the 2020 update were published.¹⁰
6. Cetin and colleagues (2022) conducted a randomized controlled trial that showed patients on chemotherapy receiving telenursing (guided by COSTaRS) compared to usual care had decreased symptom severity, improved quality of life, and increased self-care management.¹¹
7. In October 2024, the 17 symptom practice guides were updated and a new practice guide for Swallowing Difficulty was added. The Self-Care Sections were re-formatted for clarity and usability. A family caregiver participated on our Steering Committee, reviewed each practice guide, and provided valuable feedback to further help write them in plain language.

In summary, we have developed 18 user-friendly remote symptom practice guides based on a synthesis of the best available evidence, validated the practice guides with oncology nurses, and used plain language to facilitate use with patients. They are available for use in routine remote support practices.

Evidence for medications is reported using the following categories:

Effective	Medications with strong evidence that they work well based on rigorously conducted studies, meta-analysis, or systematic reviews and for which the chance of harm is small compared to benefits.
Likely effective	Medications with some evidence that they work based on one rigorously conducted study (controlled trial) or multiple rigorously conducted studies using small sample size.
Expert opinion	Low-risk medications that are consistent with sound clinical practice, suggested by experts on a guideline panel, and for which limited evidence exists.
Benefits balanced with harm	Medications for which doctors or nurse practitioners and patients should weigh the benefits and harms based on patient-specific circumstances and priorities.

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Example General Assessment Form

Practice Guides for the Remote Assessment, Triage, and Self-care of Symptoms in Adults Undergoing Cancer Treatment

Date and time of encounter _____ Type of encounter (phone/in-person) _____

Type of Cancer(s) _____ Primary Oncologist _____

Other practitioners (most responsible) _____

1. Which symptom(s)

- | | | | |
|-----------------------------------------|---------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Mouth sores/Stomatitis | <input type="checkbox"/> Skin Reaction to radiation |
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea & Vomiting | <input type="checkbox"/> Sleep changes |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Fatigue/Tiredness | <input type="checkbox"/> Pain | <input type="checkbox"/> Swallowing Difficulty |
| <input type="checkbox"/> Breathlessness | <input type="checkbox"/> Fever with Neutropenia | <input type="checkbox"/> Peripheral Neuropathy | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mouth dryness/Xerostomia | <input type="checkbox"/> Skin Rash | _____ |

2. Tell me about your symptom(s) (Supporting Evidence: Expert Consensus)

(PQRST- Provoking factors, Quality, Radiating, Relieving factors, Severity, Other symptoms, Timing, Triggers, Location)

3. Conduct general symptom assessment (Supporting Evidence: Expert Consensus)

Receiving cancer treatment:

Radiation: Site of radiation _____

Chemotherapy: Name of Chemotherapy _____

Immune Checkpoint Inhibitor Therapy: Name of Immune Checkpoint Inhibitor _____

Other systemic therapy (e.g., antiestrogen, monoclonal antibodies, targeted therapies): Name of therapy: _____

Surgery: _____

Date of last treatment(s) _____

Length of time since symptom started? _____

New symptom? Yes No Unsure

Told symptom could occur? Yes No Unsure

Other symptoms? Yes No If Yes, specify _____

Recent exposure to known virus/flu? Yes No Unsure If Yes, specify _____

4. Assess current use of medications, herbs, natural health products (name, dose, current use)

Medication	Dose Prescribed	Taking as prescribed/Last dose if PRN
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /




Are any medications new or are there recent changes? Yes No If Yes, specify: _____

5. See relevant symptom practice guide(s) for further assessment, triage and self-care.

Anxiety Practice Guide

Anxiety: an emotional or physiologic response to known or unknown causes that ranges from a normal reaction to extreme dysfunction. It may impact on decision making, adherence to treatment, functioning, or quality of life; nervousness; concern; feeling of worry; apprehension.¹⁻⁵

1. Assess severity of the anxiety^{1-4,6-13}

Tell me what number from 0 to 10 best describes how anxious you are feeling (0= “no anxiety”; 10= “worst possible anxiety”) ^{2,4,6,7,14}	1 – 3	<input type="checkbox"/>	4 - 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Are you having panic attacks: <input type="checkbox"/> periods/spells of sudden fear, <input type="checkbox"/> discomfort, <input type="checkbox"/> intense worry, <input type="checkbox"/> uneasiness? ^{1-4,6,7}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Does your anxiety affect your daily activities? ^{2-4,6,7,15}	Not at all ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Does your anxiety affect your sleep? ^{2-4,6}	Not at all	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do any of these apply to you? ^{2-4,6,7} <input type="checkbox"/> History of anxiety or depression, <input type="checkbox"/> Lack of social support, <input type="checkbox"/> Recurrent/advanced disease, <input type="checkbox"/> Younger age, <input type="checkbox"/> Substance use/withdrawal, <input type="checkbox"/> Past trauma/abuse, <input type="checkbox"/> Cognitive impairment, <input type="checkbox"/> Difficulty communicating, <input type="checkbox"/> Financial problems, <input type="checkbox"/> Female, <input type="checkbox"/> Dependent children, <input type="checkbox"/> On steroids, <input type="checkbox"/> Other health issues unrelated to cancer	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Do have any concerns that are making you feel more anxious? ^{2,6} <input type="checkbox"/> Life events, <input type="checkbox"/> Waiting for test results, <input type="checkbox"/> New information about your cancer/treatment, <input type="checkbox"/> Recently completed treatment, <input type="checkbox"/> Spiritual/religious concerns?	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>		
Do you have any other symptoms? ^{2,3,6} <input type="checkbox"/> Fatigue, <input type="checkbox"/> Breathlessness, <input type="checkbox"/> Pain, <input type="checkbox"/> Sleep changes	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of hyperthyroidism): ⁸⁻¹³ <input type="checkbox"/> weight loss, <input type="checkbox"/> heart pounding or racing, <input type="checkbox"/> tremors, <input type="checkbox"/> feeling overheated, <input type="checkbox"/> fatigue/weakness, <input type="checkbox"/> diarrhea, <input type="checkbox"/> swollen base of neck	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others? ^{2,6}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
		Mild (Green)		Moderate (Yellow)		Severe (Red)

2. Triage patient for symptom management based on highest severity^{2,3,6,7}

<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days	<input type="checkbox"/> If potential for harm, refer for further evaluation immediately <input type="checkbox"/> If no, refer for non-urgent medical attention and alert if on immunotherapy. <input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications
------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for anxiety, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-4,7}

Current use	Examples of medications for anxiety*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzodiazepines - lorazepam (Ativan [®]), diazepam, (Valium [®]), alprazolam (Xanax [®]) ^{1-4,7}		Likely effective
<input type="checkbox"/>	SSRIs/SNRIs - fluoxetine (Prozac [®]), paroxetine (Paxil [®]), citalopram (Celexa [®]), venlafaxine (Effexor XR [®]), sertraline (Zoloft [®]), escitalopram (Lexapro [®]), duloxetine (Cymbalta [®]) ^{2-4,7}		Likely effective
<input type="checkbox"/>	Antipsychotics for treatment-resistant anxiety – Olanzapine (Zyprexa [®]), Risperidone (Risperdal [®]), Quetiapine (Seroquel [®]) ^{2-4,7}		Expert opinion
<input type="checkbox"/>	Anticonvulsants for treatment-resistant anxiety – gabapentin (Neurontin [®]), pregabalin (Lyrica [®]) ^{3,4}		Expert opinion

*Use of medications should be based on severity of anxiety and potential for interaction with other medications.^{2,4} Benzodiazepines are intended for short term use. Caution: may cause confusion, ataxia and falls in the elderly.^{2,4,7} No guidance for the use of cannabinoids due to lack of studies and potential negative effects on mood.¹⁶

4. Discuss self-care strategies^{1-7,17-27}

- **What helps** when you feel anxious? Reinforce as appropriate. Specify:
- What is your goal?
- Have you shared your concerns and worries with your doctor or nurse practitioner?^{2,4,6}
- Would **more information about your symptoms, cancer or your treatment** help to ease your worries? If yes, provide relevant information or suggest resources.^{1-4,6}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical activity including yoga. ^{1,2,17}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Participate in support groups and/or rely on family/friends for support. ^{1-4,6,7}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities such as relaxation therapy, meditation/breathing techniques, listening to music, progressive muscle relaxation, guided imagery, massage therapy with or without aromatherapy, acupuncture/acupressure, or other creative therapies (e.g., art). ^{1-4,6,7,18-22,27}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive-behavioural therapy , mindfulness-based stress reduction, or personal or couple counseling that provides more in-depth guidance on managing anxiety and problem solving. ^{1-5,7,23-25,27}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual counseling, meaning-focused meditation, prayer, worship, or other spiritual activities if your concerns are spiritual or religious in nature. ^{1,2,26}

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #:
How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
- Patient agrees to use medication to be consistent with prescribed regimen
Specify:
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) ONS 2019; 2) NCCN 2023; 3) ESMO 2023; 4) NCI 2023... (pages 42-55 for all references).

Appetite Loss Practice Guide

Appetite loss: a feeling of being without hunger that may be associated with cachexia.¹⁻³ In addition to an involuntary loss of appetite, cachexia can involve sustained loss of weight and skeletal muscle mass leading to functional impairment, increased treatment toxicity, poor quality of life, and reduced survival.⁴⁻⁶

1. Assess severity of the appetite loss^{2,3,7-16}

Tell me what number from 0 to 10 best describes your appetite (0= "best appetite" and 10= "Worst possible lack of appetite") ^{2,7,8,17}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your lack of appetite? ^{2,7,8}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How much have you eaten in the past 24 hours (e.g., at each meal)? ^{2,3,7-9,18}	Less than normal ^{G1}	<input type="checkbox"/>	Much less than normal ^{G2}	<input type="checkbox"/>	Not eating at all ^{G≥3}	<input type="checkbox"/>
Have you lost weight in the last 4 weeks without trying? ^{2,3,7-9} Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
How much fluid are you drinking per day? ^{2,7}	6-8 glasses	<input type="checkbox"/>	1-5 glasses	<input type="checkbox"/>	Sips	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{2,3,7}	No ^{G0}	<input type="checkbox"/>	Yes, some ^{G1}	<input type="checkbox"/>	Yes, a lot ^{G≥2}	<input type="checkbox"/>
Is there anything causing your lack of appetite: ^{2,3,7,8} <input type="checkbox"/> Recent surgery/treatment, <input type="checkbox"/> New medication, <input type="checkbox"/> Other	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Do you have any other symptoms? ^{2,3,7-9} <input type="checkbox"/> Sore or dry mouth, <input type="checkbox"/> Early fullness, <input type="checkbox"/> Taste/smell changes, <input type="checkbox"/> Nausea/ vomiting, <input type="checkbox"/> Swallowing problems, <input type="checkbox"/> Pain, <input type="checkbox"/> Constipation, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Depression, <input type="checkbox"/> Breathlessness	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ¹⁰⁻¹⁶ <input type="checkbox"/> fatigue/weakness, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> headache, <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> vision changes, <input type="checkbox"/> weight gain or loss, <input type="checkbox"/> constipation, <input type="checkbox"/> dizziness, <input type="checkbox"/> mood or behaviour changes, <input type="checkbox"/> decreased libido, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin, <input type="checkbox"/> hair loss, <input type="checkbox"/> feeling cold, <input type="checkbox"/> puffy face	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of renal toxicity): ^{11-14,16} <input type="checkbox"/> decreased urine, <input type="checkbox"/> blood in urine, <input type="checkbox"/> swelling of hands or legs, face, abdomen, <input type="checkbox"/> sudden weight gain, <input type="checkbox"/> abdominal or pelvic pain, <input type="checkbox"/> nausea/ vomiting, <input type="checkbox"/> high blood pressure, <input type="checkbox"/> drowsiness	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ^{10,11,13-16} <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> right side abdominal pain, <input type="checkbox"/> fatigue, <input type="checkbox"/> increase in bleeding/bruising	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your poor appetite affect your daily activities? ^{2,3,7-9}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>

	 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
2. Triage patient for symptom management based on highest severity^{2,7,8}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> If severe loss of appetite is stabilized, review self-care strategies <input type="checkbox"/> If severe loss of appetite is new refer for medical attention immediately and alert if on immunotherapy.

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for appetite loss, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-9,13,14,19,20}

Current use	Examples of medications for appetite*	Notes (e.g., dose, suggest to use as prescribed for appetite loss)	Evidence
<input type="checkbox"/>	Corticosteroids ^{1-4,7-9} (dexamethasone (Decadron [®]), prednisone)		Likely effective
<input type="checkbox"/>	Megestrol (Megace [®]) ^{1-3,7,8}		Benefits balanced with harms
<input type="checkbox"/>	Omega 3 fatty acids (EPA, Fish Oil) ^{2,5,9,20}		Expert Opinion
<input type="checkbox"/>	Prokinetics (metoclopramide, domperidone) for early satiety and nausea ^{2,7-9}		Expert Opinion

* Megestrol has potential for serious side effects such as blood clot.⁸ Corticosteroids offer short-lived benefit; long-term use is associated with significant toxicities.^{3,8,13,14} Prokinetics have the potential for serious side effects; metoclopramide on the central nervous system and domperidone on cardiac rhythm.⁷⁻⁹ Cannabis/Cannabinoids are not recommended.^{1,2,6,8,9,19}

4. Discuss self-care strategies^{1-5,7-9}

- **What helps** when you feel like you are not hungry?^{2,7} Reinforce as appropriate.
- What is your **goal**?^{2,3,7}
- Do you have **beliefs** about certain foods (e.g., cultural or think some foods cause cancer) or **pre-existing diet** (e.g., diabetes) that may affect your eating habits?^{2,7}
- Have you seen or spoken to a **dietitian**?^{1-5,7-9} If you are having taste changes, they can suggest ways to help lessen your symptoms.
- Would **more information** about your symptoms help you to manage them better?^{1,2} If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat small frequent meals and snacks. ^{2,3,7,8} Sitting upright for 30-60 min helps digestion.
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat foods that are cold, with less odour, or avoiding being in the kitchen during meal preparation if food odours bother you. ^{2,3}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat more when you feel most hungry. ^{2,3}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat foods that are higher in protein and calories. ^{2,3,7-9}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Buy convenience foods or ask friends/family for help if you are unable to obtain groceries and prepare meals (access to food, financial resources). ^{2,7}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink higher energy and protein drinks (Ensure, Glucerna). ^{1-3,7-9}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stay as active as possible. ^{2,3,5,7-9} (e.g., walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week)
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Track your food, fluid intake and weight in a diary. ^{2,3,8,9}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slowly increase your intake over several days, if your food intake has been very low for a long time (to prevent refeeding syndrome). ^{2,9}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:	
<input type="checkbox"/>	Referral (service & date):	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:	
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date

References: 1) ONS 2024; 2) BCCA 2018, 3) NCI 2024... (pages 42-55 for all references).

Bleeding Practice Guide

Bleeding: Loss of blood, bruising or petechiae that may be the result of a reduction in the quantity or functional quality of platelets. Acute bleeding in patients with cancer can be due to the underlying malignancy, antineoplastic therapy, or non-malignancy related factors. The most common presentations are disseminated intravascular coagulation, hemoptysis, overt gastrointestinal bleeding, and hematuria.^{1,2}

1. Assess severity of the bleeding¹⁻¹¹

Where are you bleeding from?^{1,2,11} _____

How much blood loss? ^{1,2}	Minor (e.g., 1 tsp)	<input type="checkbox"/>	Some (e.g., 1 tbsp)	<input type="checkbox"/>	Gross (e.g., ¼ cup)	<input type="checkbox"/>
Are you worried about your bleeding	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		<input type="checkbox"/>
Do you have any new bruises? ¹	No	<input type="checkbox"/>	Few	<input type="checkbox"/>	Generalized	<input type="checkbox"/>
→ Bruising/bleeding more easily than normal? ^{3,10}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you had problems with blood clotting (e.g., >10-15min)? ^{1,4,6}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
<input type="checkbox"/> Unsure						
Do you have a fever > 38° C? ³⁻¹¹	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
<input type="checkbox"/> Unsure						
Do you have any blood in your: <input type="checkbox"/> stool or is it black/tarry? ^{1-9,11} <input type="checkbox"/> urine? ^{1-3,9} <input type="checkbox"/> vomit or does it look like coffee grounds? ^{1,2} <input type="checkbox"/> phlegm/sputum when you cough? ^{1,2} <input type="checkbox"/> nose and mouth? ³ <input type="checkbox"/> other	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
If you are having menstrual periods has there been an increase bleeding? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Do you have (signs of hematological adverse effects): <input type="checkbox"/> weakness, <input type="checkbox"/> pallor, <input type="checkbox"/> less urination, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> vomiting, <input type="checkbox"/> irritability, <input type="checkbox"/> confusion, <input type="checkbox"/> seizures, <input type="checkbox"/> blood pressure changes, <input type="checkbox"/> swelling of face, hands, feet, or entire body ³⁻⁶	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
What was your last platelet count? ^{1-3,5} Date: <input type="checkbox"/> Unsure	≥ 100,000	<input type="checkbox"/>	20,000-99,000	<input type="checkbox"/>	< 20,000	<input type="checkbox"/>
→ What were the results of your last liver function blood test? ³⁻¹¹	AST/ALT: ≤ 3x ULN Total bilirubin: ≤ 1.5x ULN	<input type="checkbox"/>	>3-5x ULN 1.5-3x ULN	<input type="checkbox"/>	> 5x ULN > 3x ULN	<input type="checkbox"/>
→ Do you have (signs of hepatic adverse effects): <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> right side abdominal pain, <input type="checkbox"/> fatigue, <input type="checkbox"/> increase in bleeding/bruising ^{4,9}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of renal adverse effects): <input type="checkbox"/> decreased urine output, <input type="checkbox"/> blood in urine, <input type="checkbox"/> swelling of hands or legs, face, abdomen, <input type="checkbox"/> sudden weight gain, <input type="checkbox"/> abdominal or pelvic pain, <input type="checkbox"/> nausea, <input type="checkbox"/> vomiting, <input type="checkbox"/> high blood pressure, <input type="checkbox"/> drowsiness ^{3,5,9}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you taking medicines that increase risk of bleeding? (e.g., ibuprofen, acetylsalicylic acid, warfarin, heparin, dalteparin, tinzaparin, apixaban enoxaparin, herbal). ^{1-3,5,8} If warfarin: do you know your last INR blood count? Date: <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	Yes, acetylsalicylic acid	<input type="checkbox"/>	Yes, other blood thinners	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity¹⁻¹¹

Review self-care
 Verify medications

Review self-care
 Verify medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

Refer for medical attention immediately and alert if on immunotherapy.

Legend: → Immune Checkpoint Inhibitor therapy

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications/treatment patient is using for bleeding, including prescribed, over the counter, traditional medicines, and/or herbal supplements¹⁻¹¹

Current use	Examples of medications for bleeding	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Platelet transfusion for thrombocytopenia ¹⁻⁵		Effective
<input type="checkbox"/>	Mesna oral or IV to prevent cystitis with bleeding ¹		Likely effective
<input type="checkbox"/>	Tranexamic acid (Cyklokapron®) ^{1,2,5}		Likely effective
<input type="checkbox"/>	Pantoprazole IV (Panto IV®) for GI bleeding ²		Expert opinion
<input type="checkbox"/>	Octreotide IV (Sandostatin®) for GI bleeding ²		Expert opinion
<input type="checkbox"/>	→ Corticosteroids/prednisone ³⁻¹¹		Expert opinion
<input type="checkbox"/>	→ Factor replacement for acquired hemophilia ³		Expert opinion
<input type="checkbox"/>	→ Eculizumab for hemolytic uremic syndrome ³		Expert opinion

Legend: → Immune Checkpoint Inhibitor therapy

4. Discuss self-care strategies^{1,3,5,7,8}

- Have you seen or spoken to a pharmacist, doctor, or nurse practitioner about **medications** you are taking that **may affect bleeding**?^{1,3,8}
- Would **more information** about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.^{1,5,7,8}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apply direct pressure for 10-15 minutes when the bleeding occurs. ¹
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use ice packs to control bleeding of a wound. ¹
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Minimize dressing changes when there is bleeding and use saline fluids to soak the dressing before it is removed. ¹
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use special dressings to control bleeding of a wound (e.g., non-stick gauze, medicated dressing, packing). ¹

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
- Patient agrees to use medication to be consistent with prescribed regimen
Specify:
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) ONS 2019; 2) AHS 2022; 3) ASCO 2021; 4) CCO 2018... (pages 42-55 for all references).

Breathlessness/Dyspnea Practice Guide

Breathlessness/Dyspnea: A subjective experience described as breathing discomfort of varying intensities (e.g., hard to breathe, feeling smothered, tightness in chest, unable to catch breath, panting, gasping).¹⁻⁶

1. Assess severity of the breathlessness¹⁻²¹

What number from 0 to 10 best describes your shortness of breath (0= "no shortness of breath"; 10= "Worst possible shortness of breath"? ^{2-4,7,22}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your shortness of breath? ^{2-4,7}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you pause while talking every 5-15 seconds? ^{2,7}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is your breathing noisy, rattily or congested? ^{2,7}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a new cough or wheezing? ^{2,8,9}	No	<input type="checkbox"/>	Yes (dry)	<input type="checkbox"/>	Yes (wet)	<input type="checkbox"/>
→Do you have (signs of pneumonitis): ^{1,2,5,10-18} <input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> chest pain, <input type="checkbox"/> fever, <input type="checkbox"/> fatigue, <input type="checkbox"/> bluish coloured nail beds	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you wake suddenly short of breath? ^{2,4,7-9}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ^{2,8,19} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
What was your last red blood cell count? ^{2,5,6,8,23} <input type="checkbox"/> Unsure	≥100 ^{G1}	<input type="checkbox"/>	80-99 ^{G2}	<input type="checkbox"/>	<80 ^{G3}	<input type="checkbox"/>
Do you have new pale skin or bluish coloured nail beds? ^{2,7-9}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have chest pain? ^{2,8}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
♥ Does it go away with: <input type="checkbox"/> Rest or <input type="checkbox"/> Medication? ¹⁹	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
What activity level are you short of breath? ^{2,4,7,9,19,20,23}	Moderate ^{G1}	<input type="checkbox"/>	Mild ^{G2}	<input type="checkbox"/>	At rest ^{G≥3}	<input type="checkbox"/>
Do you have any other symptoms? ^{2,4,7,9,20} <input type="checkbox"/> Fatigue, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Depression, <input type="checkbox"/> Pain	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
♥ Have you gained or lost weight in the last week? ⁹ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	≥4lbs in 2 days; 5lbs in 1 week	<input type="checkbox"/>	≥5lbs in 2 days	<input type="checkbox"/>
Have you raised the head of your bed or increased the number of pillows you need to sleep? ^{2,7-9,19,20}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Need to sleep in a chair	<input type="checkbox"/>
Do you have swelling in your hands, ankles, feet, legs or stomach? ^{2,7-9,19-21}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have a fast heartbeat that does not slow down when you rest? ^{2,8,19,21}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→Do you have (signs of cardiovascular toxicity): ^{10-13,17} <input type="checkbox"/> irregular heartbeat (e.g., pounding, fast, skipping beats, fluttering), <input type="checkbox"/> fatigue, <input type="checkbox"/> chest pain	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your shortness of breath affect your daily activities? ^{2,4,5,7}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage for symptom management based on highest severity^{2,5,7,8,10,11,13-18}

Review self-care
 Verify medications

Review self-care
 Verify medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

Refer for medical attention immediately and alert if on immunotherapy.

Legend: → Immune Checkpoint Inhibitor therapy; ♥ Cardiology; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3+

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications for shortness of breath, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-20,24,25}

Current use	Examples of medications for shortness of breath*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Immediate-release oral or parenteral opioids ^{1-7,9}		Effective
<input type="checkbox"/>	Non-invasive ventilation (CPAP mask) ^{1,3-5}		Likely effective
<input type="checkbox"/>	Oxygen for hypoxic patients ^{2-7,9}		Expert Opinion
<input type="checkbox"/>	Bronchodilators ^{2,3,6}		Expert Opinion
<input type="checkbox"/>	♥ Diuretics (Edecrin®, Lasix®, Lozide®, Zaroxolyn®) 2,5,8,9,19,20		Effective
<input type="checkbox"/>	♥ Nitrates (Nitrostat®) ^{8,9,19,20,25}		Benefits Balanced with Harm
<input type="checkbox"/>	Benzodiazepines if anxiety related - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®) ^{2,4-7,9,24}		Expert Opinion
<input type="checkbox"/>	→ Corticosteroids, infliximab, mycophenolate mofetil, or cyclophosphamide for pneumonitis ^{1,3-5,10-18}		Expert Opinion

*Palliative oxygen is not recommended;^{1,4} Other medications may be prescribed for heart failure.

4. Discuss self-care strategies^{1-9,12,13,19,20,24,25}

- **What helps** when you are short of breath?^{2,3,7} Reinforce as appropriate. Specify:
- What is your **goal**?^{2,3,7,8}
- Would **more information about your symptoms** help you to manage them better?^{1,2,7,8} If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try a fan, open window , or humidifier to increase air flow to your face. ^{1-7,9}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try turning down the temperature in your house. ²
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to rest in upright positions that can help you breathe. ^{2-4,7,9}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try different relaxation and breathing exercises (e.g., pursed lip breathing). ^{2-5,7}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to conserve your energy (e.g., balance activity with rest) or use assistive devices (e.g., wheelchair) to help with activities that cause your shortness of breath. ^{2-4,6,7,9}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try physical activity (e.g., walking 15-30 min) twice a week when breathing stable. ^{1-4,8,9,19,24,25}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take nutrition supplements if you have difficulty eating. ¹
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ Watch weight gain from retaining fluid by weighing yourself daily at same time. ^{8,9,20}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ Try limiting your salt intake to under 1/2 tsp (< 2000mg) per day. ^{8,9,20}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ If you drink >1-2 alcohol drinks/day, try to reduce to 1 drink/day . ^{8,9,19,20}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you smoke, try to stop. ^{2,8,9,12,13,19,20,25}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try a program such as cognitive behavioural therapy , relaxation therapy, guided imagery, meditation, music therapy, acupressure, acupuncture, or supportive counselling . ^{1-5,7}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____	
<input type="checkbox"/>	Referral (service & date): _____	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____	
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date




References: 1) ONS 2019; 2) BCCA 2018; 3) ASCO 2021; 4) ESMO 2020... (pages 42-55 for all references).

Constipation Practice Guide

Constipation: A decrease in the frequency or passage of stool usually characterized by stools that are hard.¹⁻⁶

1. Assess severity of the constipation¹⁻¹³

Tell me what number from 0 to 10 best describes your constipation (0= "no constipation"; 10= "worst possible constipation") ^{2,3,6,14}	1 – 3	<input type="checkbox"/>	4 - 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Are you worried about your constipation? ^{2,3}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How many days has it been since you had a bowel movement (compared to normal)? ¹⁻⁵	≤ 2 days	<input type="checkbox"/>	≥3 days	<input type="checkbox"/>	≥3 days on meds	<input type="checkbox"/>
How would you describe your stools (colour, hardness, odour, amount, blood, straining)? ¹⁻⁷					Blood in stool	<input type="checkbox"/>
Do you have hemorrhoids? ³	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have any pain in your abdomen? ¹⁻⁶	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you have loss of bladder or bowel control, numbness in your fingers, toes or buttocks, feel unsteady on your feet, or difficulty walking? ^{2-4,6}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your abdomen feel bloated? ^{2-4,6} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have lots of gas? ^{2-4,6}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does it feel like your rectum is not emptying after a bowel movement, or diarrhea (possible overflow around blocked stool)? ^{2-4,6}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Have you recently had abdominal surgery? ^{2,3}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ³ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ²⁻⁶	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have any other symptoms? <input type="checkbox"/> Appetite loss, ¹⁻³ <input type="checkbox"/> Nausea/vomiting ^{2,6}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of hypothyroidism): ^{1-3,5,7-13} <input type="checkbox"/> weight gain, <input type="checkbox"/> fatigue, <input type="checkbox"/> depression, <input type="checkbox"/> feeling cold, <input type="checkbox"/> deeper voice, <input type="checkbox"/> hair loss, <input type="checkbox"/> dry skin	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of autonomic neuropathy): ^{3-5,7,8} <input type="checkbox"/> nausea, <input type="checkbox"/> urinary problems, <input type="checkbox"/> sweating changes	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you taking medications that cause constipation? ¹⁻⁶	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does your constipation affect your daily activities? ^{2,3,15}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>

	 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
2. Triage patient for symptom management based on highest severity³	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours	<input type="checkbox"/> Refer for medical attention immediately and alert if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for constipation, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-6,16}

Current use	Examples of medications for constipation*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Oral sennosides (Senokot®) ^{1-6,16}		Likely effective
<input type="checkbox"/>	Polyethylene glycol (PEG; RestoraLAX®, Lax-a-day®) ^{1-6,16}		Likely effective
<input type="checkbox"/>	Bisacodyl (Dulcolax®) and/or lactulose ^{1-6,16}		Expert Opinion
<input type="checkbox"/>	Suppositories** (Dulcolax®/bisacodyl, glycerin) or Enema ^{2-6,16}		Expert Opinion
<input type="checkbox"/>	Picosulfate sodium-magnesium oxide-citric acid ^{2,4,6,16}		Expert Opinion
<input type="checkbox"/>	Methylnaltrexone injection for opioid as cause ¹⁻⁶		Effective
<input type="checkbox"/>	Naloxegol for opioid as cause ^{1,5}		Expert Opinion
<input type="checkbox"/>	Sorbitol ^{2,3,6}		Expert Opinion

*Some opioids cause less constipation (e.g., fentanyl);^{3,6} Docusate sodium (Colace®) was removed due to lack of evidence for its efficacy;
 **Verify blood count before using suppositories. Naloxegol and methylnaltrexone are contraindicated in bowel obstruction.^{3,5}

4. Discuss self-care strategies^{1-6,16}

- **What helps** when you are constipated?²⁻⁴ Reinforce as appropriate. Specify:
- What is your **goal**?^{1,2}
- What is your normal **bowel routine**?²⁻⁵ Reinforce as appropriate. Specify:
- Have you seen or spoken to a doctor, nurse practitioner, pharmacist or dietitian about the constipation?¹⁻³
- Would **more information** about your symptoms help you to manage them better?³ If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to use the toilet 30-60 minutes after meals. ^{3,4,6}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink fluids, 6-8 glasses per day, especially warm or hot fluids. Limit your intake of caffeine or alcohol. ¹⁻⁶
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slowly increase the fiber in your diet to 25g/day. (Only appropriate if adequate fluid intake (1500ml/24 hrs) and physical activity) ¹⁻⁴
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat fruit that are laxatives. ^{3,4} (pitted dates, prunes, prune nectar, figs)
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try staying as active as possible. (e.g., walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week) ^{1-6,16}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have easy access to a private toilet or bedside commode. If possible, it is best to avoid a bedpan. ²⁻⁶
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a low neutrophil count, avoid rectal exams, suppositories, enemas. ^{2-4,6}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consider trying acupuncture. ¹⁶

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) ONS 2020; 2) CCO 2022; 3) BCCA 2018; 4) NCI 2023; 5) AHS 2018... (pages 42-55 for all references).

Depression Practice Guide

Depression: a range of feelings and emotions from normal sadness to chronic, depressed emotional affect, feelings of despair, irritable mood, hopelessness.¹⁻⁵

1. Assess severity of the depression^{1-4,6-12}

Are you currently receiving professional care for depression? Yes No Specify: _____

What number from 0 to 10 best describes how depressed you are feeling where 0 = "no depression" and 10 = "worst possible depression" ^{2,6,7,13}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Have you felt depressed or had a loss of pleasure for 2 weeks or longer? ^{1-4,6,7}	No	<input type="checkbox"/>	Yes, off/on	<input type="checkbox"/>	Yes, constant	<input type="checkbox"/>
Do you feel down or depressed most of the day? ^{3,4,6}	No	<input type="checkbox"/>	Yes, off/on	<input type="checkbox"/>	Yes, every day	<input type="checkbox"/>
Have you experienced any of the following for ≥ 2 weeks: <input type="checkbox"/> feeling worthless, <input type="checkbox"/> sleeping too little or too much, <input type="checkbox"/> feeling guilty, <input type="checkbox"/> weight gain or weight loss, <input type="checkbox"/> unable to think or concentrate? ^{1-4,7}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others? ^{1-4,6,7}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does feeling depressed affect your daily activities? ^{1-4,6,14}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Have you felt tired/fatigued? (ESAS-r fatigue rating) ^{1-4,7}	No, 1-3	<input type="checkbox"/>	Yes, 4-6	<input type="checkbox"/>	Yes, 7-10	<input type="checkbox"/>
Have you felt agitated (may include twitching or pacing), confused, or slowing down of your thoughts? ¹⁻⁴	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Do any of these apply to you? ^{1-4,6,7} <input type="checkbox"/> Lack of social support, <input type="checkbox"/> History of depression, <input type="checkbox"/> Substance use/withdrawal, <input type="checkbox"/> Chronic/advanced disease, <input type="checkbox"/> Younger age, <input type="checkbox"/> Financial problems, <input type="checkbox"/> Female, <input type="checkbox"/> Dependent children, <input type="checkbox"/> Past trauma/abuse, <input type="checkbox"/> Cognitive impairment, <input type="checkbox"/> Difficulty communicating, <input type="checkbox"/> Other health issues unrelated to cancer?	None	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do have any concerns that are making you feel more depressed: ^{2,6} <input type="checkbox"/> Life events, <input type="checkbox"/> Waiting for test results, <input type="checkbox"/> New information about cancer/treatment, <input type="checkbox"/> Recently completed treatment, <input type="checkbox"/> Spiritual/religious concerns?	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>		
Do you have any other symptoms? ^{1,2,4,6,7} <input type="checkbox"/> Fatigue, <input type="checkbox"/> Pain, <input type="checkbox"/> Sleep changes, <input type="checkbox"/> Anxiety	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→Do you have (signs of hypothyroidism): ^{4,7-12} <input type="checkbox"/> Weight gain, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Constipation, <input type="checkbox"/> Feeling cold, <input type="checkbox"/> Deeper voice, <input type="checkbox"/> Hair loss, <input type="checkbox"/> Dry skin	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>

1 Mild (Green) **2** Moderate (Yellow) **3** Severe (Red)

2. Triage patient for symptom management based on highest severity^{1-3,6,7}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days	<input type="checkbox"/> If potential for harm, refer for further evaluation immediately <input type="checkbox"/> If no, refer for non-urgent medical attention and alert if on immunotherapy. <input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for depression, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-4,7,15}

Current use	Examples of medications for depression*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	SSRIs - fluoxetine (Prozac [®]), sertraline (Zoloft [®]), paroxetine (Paxil [®]), citalopram (Celexa [®]), fluvoxamine (Luvox [®]), escitalopram (Lexapro [®]) ^{1-4,7,15}		Effective
<input type="checkbox"/>	SNRIs - venlafaxine (Effexor XR [®]), duloxetine (Cymbalta [®]) ^{1,3,4}		Effective
<input type="checkbox"/>	Tricyclic antidepressants - amitriptyline (Elavil [®]), imipramine (Tofranil [®]), desipramine (Norpramin [®]), nortriptyline (Pamelor [®]), doxepin (Sinequan [®]) ^{1,15}		Effective
<input type="checkbox"/>	Psychostimulants - methylphenidate (Ritalin [®]) ^{1-4,7}		Effective
<input type="checkbox"/>	Other antidepressants - bupropion (Wellbutrin [®]), trazodone (Mylan [®]), mirtazapine (Remeron [®]), Mianserina (Tolvon [®]) ^{1,4,7,15}		Effective

*Antidepressant medication is effective for major depression but use depends on side effect profiles of medications and the potential for interaction with other medications.¹⁻⁴ No guidance for the use of cannabinoids due to lack of studies and potential negative effects on mood.¹⁶

4. Discuss self-care strategies^{1-7,17-24}

- **What helps** when you feel depressed?⁷ Reinforce as appropriate. Specify:
- What is your **goal**?
- Do you feel you have **enough help at home** and with getting to appointments/ treatments (transportation, financial assistance, medications)?^{2,3,6}
- Are you agreeable to a referral to a mental health professional for further help?^{1-4,6,7}
- Would more **information about your symptoms, cancer or your treatment** help to ease your worries? If yes, provide relevant information or suggest resources.^{1,2,6,7}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical activity including yoga. ^{1,2,6,7,17}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Participate in support groups and/or rely on family/friends for support. ^{1-4,6,7}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities such as relaxation therapy, meditation/breathing techniques, listening to music, progressive muscle relaxation, guided imagery, massage therapy with or without aromatherapy, acupuncture/acupressure, or other creative therapies (e.g., art). ^{1-4,7,19,24}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cognitive-behavioural therapy , mindfulness-based stress reduction or received personal or couple counseling that provides more in-depth guidance on managing depression. ^{1-7,20-22,24}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual counseling, meaning-focused meditation, prayer, worship, or other spiritual activities if your concerns are spiritual or religious in nature. ^{2-4,23}

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #: _____
How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
- Patient agrees to use medication to be consistent with prescribed regimen
Specify: _____
- Referral (service & date): _____
- Patient agrees to seek medical attention; specify time frame: _____
- Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) ONS 2019; 2) NCCN 2023; 3) ESMO 2023; 4) NCI 2024... (pages 42-55 for all references).




Diarrhea Practice Guide

Diarrhea: An abnormal increase in stool liquidity and frequency over baseline which may be accompanied by abdominal cramping.¹⁻⁶

1. Assess severity of the diarrhea¹⁻¹⁸

Have you been tested for c-difficile?^{1-5,7-17} Yes No Unsure Results _____

Tell me what number from 0 to 10 best describes your diarrhea (0 = "no diarrhea"; 10 = "worst possible diarrhea") ¹⁹	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your diarrhea? ^{2,3}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How many extra bowel movements are you having per day above normal for you? ^{1-3,5,7,15,20}	< 4 ^{G1}	<input type="checkbox"/>	4-6 ^{G2}	<input type="checkbox"/>	≥ 7 ^{≥G3}	<input type="checkbox"/>
Do you wake in the night to have bowel movements? ^{2,7}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Ostomy: increase in output above normal? ^{2,7,15,20}	Small	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Large	<input type="checkbox"/>
→ Bowel movements/day above normal? ^{6,8-14,16,17,20}			< 4 ^{G1}	<input type="checkbox"/>	≥ 4 ^{≥G2}	<input type="checkbox"/>
→ Ostomy: increase in output above normal? ^{10,13,16,17}			Small	<input type="checkbox"/>	≥ Moderate	<input type="checkbox"/>
→ Diarrhea overnight or new incontinence? ^{8,9,11,14,16}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How would you describe your stools (colour, hardness, odour, amount, oily, blood, mucus, straining)? ^{1-3,5,7}					Blood in stool	<input type="checkbox"/>
→ Blood or mucus in stool? ^{6,8-14,16}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ^{1-3,5,7-12,14-17} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have pain in your abdomen or rectum with or without cramping or bloating? ^{1-3,5,7,15,18}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Pain or cramping in your abdomen? ^{6,8-12,14,16,17}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How much fluid are you drinking per day? ^{2,3,5}	6-8 glasses	<input type="checkbox"/>	1-5 glasses	<input type="checkbox"/>	Sips	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{1-3,5,7,9,12,15}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Does your diarrhea affect your daily activities? ^{2,3,7,8,10,11,14-16}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have any other symptoms? ^{1-3,5,7,15,18} <input type="checkbox"/> Appetite Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Mouth sores	No	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ New severe fatigue, headache, rash, cough, nausea, vomiting, breathlessness, weight loss, vision changes, eye pain, muscle weakness, joint pains, or mood changes? ^{11-13,17}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you on medicines that increase risk of diarrhea (e.g., laxatives)? ^{2,3,5,10,15,17}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Any recent travel or contact with others with diarrhea? ^{2,4,5,7,15}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have any rectal or ostomy skin breakdown? ^{2,3,7}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		

 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
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2. Triage patient for symptom management based on highest severity^{1-3,5,7-17}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately and alert if on immunotherapy.
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Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for diarrhea, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-17,21}

Current use	Examples of medications for diarrhea*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	First line treatment: Loperamide (Imodium®) ^{1-5,7,15}		Likely effective
<input type="checkbox"/>	Octreotide (Sandostatin®) for severe chemo-induced ^{1-5,7,15}		Likely effective
<input type="checkbox"/>	Psyllium fibre for radiation-induced (Metamucil®) ^{1,4}		Likely effective
<input type="checkbox"/>	Probiotics for radiation-induced / for chemo-induced ^{1,4,5,15,21}		Effective / Likely effective
<input type="checkbox"/>	Atropine-diphenoxylate (Lomotil®) ^{5,11,15}		Expert opinion
<input type="checkbox"/>	Corticosteroid cream if rectal skin irritated ³		Expert opinion
<input type="checkbox"/>	→ Loperamide (Imodium®) ^{5,6,8-12,14,16,17}		Likely effective
<input type="checkbox"/>	→ Corticosteroids/prednisone, ^{2,5,6,8-17} Infliximab, ^{5,6,8-14,16,17} Vedolizumab, ^{5,8,10-13} or Budesonide ^{5,11,12} for severe diarrhea		Likely effective

→ Immune Checkpoint Inhibitor. *For radiation induced diarrhea, sucralfate^{1,18} and oral antibiotics are generally not recommended.²

4. Discuss self-care strategies^{1-5,7,9-12,15-18}

- **What helps** when you have diarrhea?^{2,3} Reinforce as appropriate. Specify:
- What is your **goal**?³
- Have you seen or spoken to a doctor, nurse practitioner, or pharmacist about **medications** you may be taking that **can cause or worsen your diarrhea**?^{2,3,5,7}
- Have you seen or spoken to a **dietitian**?^{5,7,16}
- Would **more information** about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink fluids, 6-8 glasses per day. ^{1-5,7,9-12,15,16}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to replace electrolytes (e.g., potassium and salt). ^{1-5,7,9,15,17} Suggest: bananas, potatoes, sports drinks, oral rehydration (1/2 tsp salt, 6 tsp sugar, 4C water)
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try eating foods such as: applesauce, oatmeal, bananas, barley, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned poultry, mashed potatoes, fruit without skin (high in soluble fiber, low in insoluble fiber) ^{1-3,9-12,18}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid eating foods such as: greasy/fried and spicy foods, alcohol, <2-3 servings caffeine, excess fruit juice or sweetened fruit drinks, raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes, very hot or cold foods/fluids, sorbitol in sugar-free candy, lactose-containing products (milk, yoghurt, cheese). ^{1-5,7,9-11,15,16}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat small frequent meals and snacks. ^{1-3,7,15}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to keep skin around your rectum or ostomy clean to avoid skin breakdown (mild soap, sitz baths). ^{2,3,5} Cleanse perianal skin with warm water (+/- mild soap) after each stool. Moisture barrier cream if not on radiation therapy. Hydrocolloid dressings may be used as a physical barrier to protect skin.
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keep track of the number of stools you are having and be aware of other problems such as fever and dizziness. ^{2,5,7}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use strategies to help cope such as planning all outings, carrying a change of clothes, knowing the location of restrooms, using absorbent undergarments. ³

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #:
- How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
- Patient agrees to use medication to be consistent with prescribed regimen. Specify:
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to notify in 12-24 hours if no improvement, symptom worsens, or new symptoms occur




Name	Signature	Date
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References: 1) ONS 2024; 2) BCCA 2018; 3) CCO 2022; 4) AGIHO/AGIHO 2018... (pages 42-55 for all references).

Fatigue/Tiredness Practice Guide

Fatigue: a distressing, persistent, subjective sense of physical, emotional, and/or cognitive tiredness or exhaustion prompted by cancer or cancer treatment that is disproportionate to the level of recent exertion, is not relieved by rest or sleep, and interferes with usual daily activities.¹⁻¹¹

1. Assess severity of the fatigue/tiredness^{1-5,12-21}

What number from 0 to 10 best describes how tired you are feeling where 0= "no tiredness" and 10= "worst possible tiredness" ^{1-3,5,12,22}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your fatigue? ^{1,12}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have shortness of breath at rest, sudden onset of severe fatigue, need to sit or rest too much, rapid heart rate, rapid blood loss, or pain in your chest? ^{1,4,12}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How would you describe the pattern of fatigue? ^{1-5,12}	On and off	<input type="checkbox"/>	Constant < 2wks	<input type="checkbox"/>	Constant ≥ 2wks	<input type="checkbox"/>
Does your fatigue affect your daily activities? ^{1-5,12,23}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Do you have a fever > 38° C? ^{1,2,12} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you know the results of your last hemoglobin (Hgb) blood test? ^{1-4,12} Date: <input type="checkbox"/> Unsure	<LLN-10.0g/dL	<input type="checkbox"/>	<10.0-8.0 g/dL	<input type="checkbox"/>	<8.0 g/dL	<input type="checkbox"/>
Have you lost or gained weight in the last 4 weeks without trying? ^{1,2,4,12} Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
Do you have any other symptoms? ^{1-4,12} <input type="checkbox"/> Anxiety, <input type="checkbox"/> Pain, <input type="checkbox"/> Appetite loss, <input type="checkbox"/> Depression, <input type="checkbox"/> Sleep changes, <input type="checkbox"/> Poor food or fluid intake	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ^{2,4,13-21} <input type="checkbox"/> appetite loss, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> headache, <input type="checkbox"/> nausea/vomiting, <input type="checkbox"/> vision changes, <input type="checkbox"/> weight gain or loss, <input type="checkbox"/> constipation, <input type="checkbox"/> dizziness, <input type="checkbox"/> mood or behaviour changes, <input type="checkbox"/> decreased libido, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin, <input type="checkbox"/> hair loss, <input type="checkbox"/> feeling cold, <input type="checkbox"/> puffy face	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of pneumonitis): ¹³⁻²¹ <input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> breathlessness, <input type="checkbox"/> chest pain, <input type="checkbox"/> fever, <input type="checkbox"/> bluish coloured nail beds	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of cardiovascular toxicity): ^{13-18,20} <input type="checkbox"/> irregular heartbeat (e.g., pounding, fast, skipping beats, fluttering), <input type="checkbox"/> chest pain, <input type="checkbox"/> breathlessness	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ¹³⁻¹⁹ <input type="checkbox"/> yellow skin/ eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> right side abdominal pain, <input type="checkbox"/> appetite loss, <input type="checkbox"/> increase in bleeding/bruising	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of myositis): ^{13-16,19,20} <input type="checkbox"/> limb weakness, <input type="checkbox"/> difficulty standing up, lifting arms, moving around, <input type="checkbox"/> muscle pain	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hemolytic uremic syndrome): ¹⁴ <input type="checkbox"/> blood in urine/stool or nose/mouth, <input type="checkbox"/> less urine, <input type="checkbox"/> new/unexplained bruises, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> pale skin, <input type="checkbox"/> vomiting, <input type="checkbox"/> confusion/seizures, <input type="checkbox"/> swelling	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have conditions that cause fatigue ^{1-5,12,13} (cardiac, lung, liver, kidney, endocrine, neurologic) or drink excess alcohol?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking medicines that increase fatigue? ^{1-4,12,13,15} (e.g., for pain, depression, nausea/vomiting, allergies)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
	 1	Mild (Green)	 2	Moderate (Yellow)	 3	Severe (Red)
2. Triage patient for symptom management based on highest severity^{1-3,5,12-16,18-20}	<input type="checkbox"/> Review self-care		<input type="checkbox"/> Review self-care. <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		<input type="checkbox"/> If stable, review self-care strategies <input type="checkbox"/> If new, refer for non-urgent medical attention and alert if on immunotherapy	

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for fatigue, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-5,24}

Current use	Examples of medications for fatigue*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Ginseng (American or Asian) ^{2,4,5,24}		Likely effective
<input type="checkbox"/>	Methylphenidate (Ritalin®) ^{2,4,5}		Expert opinion
<input type="checkbox"/>	Corticosteroids: dexamethasone (Decadron®), prednisone ¹⁻⁵		Benefits balanced with harms

*Use of pharmacological agents for cancer-related fatigue is experimental. Methylphenidate may be considered with caution after ruling out other causes of fatigue.^{2,4,5} Corticosteroids offer short-lived benefit; long-term use is associated with significant toxicities.^{2,3,5}

4. Discuss self-care strategies^{1-13,15,25-32}

- **What helps** when you feel fatigued/tired?^{1,12} Reinforce as appropriate. Specify:
- What is your **goal**?^{1,2}
- Do you understand the difference between **cancer-related fatigue** and normal fatigue?^{1-5,12} Provide education about how it differs from normal fatigue, that it is expected with cancer treatment.
- If you need a **tailored plan**, have you seen or spoken to or would you like to speak with a health care professional to help guide you in managing your fatigue?^{1,2,5,25} (e.g., rehabilitation specialist)
- Would **more information** about your symptoms help you to manage them better?^{1-3,12,15} If yes, provide relevant information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Track your fatigue patterns in a diary to help with planning activities. ^{2-5,12,13}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Save energy for things that are important to you. ^{1-5,12,13}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical activity including yoga. ^{1-6,8,10,12,13,25-29} Set goals based on current health status. Suggest starting with light activity and gradually increase to 20 min of endurance activities (e.g., walking, jogging, swimming) and resistance activities (e.g., light weights). Use caution for patients with some conditions (e.g., bone metastases).
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat/drink enough to meet your body's energy needs. ^{1,2,4,5,12,13,15} Staying hydrated and a balanced diet (e.g., vitamins, minerals) can help fatigue.
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try activities like reading, games, music, garden, experiences in nature. ^{4,12,30}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Participate in support groups or rely on family/friends . ^{1,2,12}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activities such as relaxation therapy, deep breathing, guided imagery, massage with or without aromatherapy, acupressure or acupuncture. ^{1-5,11,13,32}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try the following to improve the quality of your sleep . ^{1,2,5,12,15} Ensure light exposure soon after waking; avoid long/late afternoon naps; limit time in bed to actual sleep; go to bed when sleepy; use bed for sleep and sexual activity only; have routine schedule for bedtime and getting up; avoid caffeine and stimulating activity in the evening; relax for 1 hour before going to bed; establish a bedtime routine.
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try cognitive behavioural therapy or mindfulness-based stress reduction to manage your fatigue. ^{1-5,7,9,12,13,31}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try home-based bright white light therapy . ^{1,2}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Referral (service & date): _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur
Name	Signature
	Date

References: 1) BCCA 2018; 2) NCCN 2023; 3) ESMO 2020; 4) NCI 2024... (pages 42-55 for all references).

Fever with Neutropenia Practice Guide

Fever with neutropenia: An absolute neutrophil count (ANC) < 500 cells/mcl (equivalent to < 0.5 x 10⁹/L) OR an ANC < 1000 cells/mcl (< 1.0 x 10⁹/L) and a predicted decline to 500 cells/mcl or less over the next 48 hours AND a single oral temperature of ≥38.3° C (101 °F) or a temperature of ≥38.0° C (100.4 °F) for ≥1 hour.¹⁻¹¹

1. Assess severity of the fever and neutropenia¹⁻¹⁹




If receiving chemotherapy or immunotherapy, what was the date of your last treatment?^{1,2,4} _____

Have you been recently taking antibiotics?^{1,9} No Yes <48 hours Yes ≥48 hours

What is your temperature in the last 24 hours?^{1-5,7-10} Current: _____ Previous temperatures: _____

Have you taken any acetaminophen (Tylenol®) or ibuprofen (Advil®),² if yes, how much and when? _____

Do you have an oral temperature of ≥38.0°C (100.4 °F)? ^{1-5,7-10} Adjust if measured by other methods (e.g., ear, forehead)	No <input type="checkbox"/>	Yes for <1 hour <input type="checkbox"/>	Yes for ≥1 hour <input type="checkbox"/>
Last known neutrophil count ^{1-11,20} _____ Date: <input type="checkbox"/> Unsure	>1000 cells/mcl <input type="checkbox"/>		Fever plus ≤500 cells/mcl or 1000 cells/mcl with expected drop ^{G3} <input type="checkbox"/>
Do you have any other symptoms? ^{2,8,9} <input type="checkbox"/> Bleeding, <input type="checkbox"/> Breathlessness, <input type="checkbox"/> Constipation, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Mouth sores, <input type="checkbox"/> Mouth dryness, <input type="checkbox"/> Nausea, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Skin reaction to radiation, <input type="checkbox"/> Urinary symptoms (burning, urgency, frequency)	None <input type="checkbox"/>	Some <input type="checkbox"/>	Yes, many <input type="checkbox"/>
→ Do you have (signs of GI toxicity): ¹²⁻¹⁷ <input type="checkbox"/> abdominal pain, <input type="checkbox"/> diarrhea, <input type="checkbox"/> blood or mucus in stool, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> vomiting, <input type="checkbox"/> weight loss	No <input type="checkbox"/>		Yes <input type="checkbox"/>
→ Do you have (signs of pneumonitis): ^{13,15-19} <input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> chest pain, <input type="checkbox"/> fever, <input type="checkbox"/> fatigue, <input type="checkbox"/> bluish coloured nail beds	No <input type="checkbox"/>		Yes <input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ^{14,16,17,19} <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> right side abdominal pain, <input type="checkbox"/> fatigue, <input type="checkbox"/> appetite loss, <input type="checkbox"/> increase in bleeding/bruising	No <input type="checkbox"/>		Yes <input type="checkbox"/>
→ Do you have (signs of aseptic meningitis): ^{14,15,18} <input type="checkbox"/> headache, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> neck stiffness, <input type="checkbox"/> low-grade fever, <input type="checkbox"/> nausea, <input type="checkbox"/> vomiting	No <input type="checkbox"/>		Yes <input type="checkbox"/>

 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
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2. Triage patient for symptom management based on highest severity^{1-7,9-11,21}

<input type="checkbox"/> Review self-care <input type="checkbox"/> Advise to notify if symptom worsens or new symptoms occur in 12-24 hours	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Advise to notify if symptom worsens or new symptoms occur in 12-24 hours <input type="checkbox"/> If ≥38.0° for <1 hour, advise to notify if still ≥38.0 after 1 hour.	<input type="checkbox"/> Refer for medical attention immediately and alert if on immunotherapy. Febrile neutropenia treatment with antibiotics should be initiated within 1 hour of presentation. Collect laboratory data to locate potential site or cause of infection prior to starting antibiotics.
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Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G3=Grade 3

Note: For consistency across symptom practice guides a temperature of 38.0° C is used.

Additional Comments:

3. Review medications patient is using for preventing febrile neutropenia or decreasing fever, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-11,21}

Current use	Examples of medications*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	G(M)-CSF for at-risk patients ^{1-6,8,10,21}		Effective
<input type="checkbox"/>	Antibiotics to prevent infection for high-risk patients ^{1-3,5-9,11}		Effective
<input type="checkbox"/>	Antifungals to prevent infection for at-risk patients ^{1-3,5,8,9,11}		Effective
<input type="checkbox"/>	Antivirals for select at-risk patients ^{1,3,5,8,9}		Effective

*Use of over the counter medications to lower fever in cancer patients (e.g., acetaminophen) is controversial and should not be used to mask a fever of unknown origin.²

4. Discuss self-care strategies^{1-3,5,8,9}

- Have you seen or spoken to a doctor or nurse practitioner about getting vaccines (e.g., flu shot, COVID-19 with inactivated vaccine)?^{1-3,5} All visitors and household members should **be up-to-date with vaccines** (e.g., influenza, COVID-19, measles, mumps, rubella, and varicella).
- Would **more information** about your symptoms help you to manage them better?² If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If temperature not $\geq 38.0^{\circ}$ C, perform regular checks using a thermometer in your mouth and track your temperature in a diary. ² Avoid rectal temperature measurements. ¹
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wash your hands and/or use alcohol-based sanitizer prior to handling foods, before and after eating, after using the washroom, coughing or sneezing in hands. ^{2,3,8}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consider drinking fluids , 6-8 glasses per day to stay hydrated. ²
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid enemas, suppositories, tampons, and invasive procedures (e.g., rectal exams, colonoscopy). Constipation and straining during bowel movements can cause trauma to rectal tissue. ²
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid crowds and people who might be sick. ^{2,5,9}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat well cooked foods and/or well cleaned uncooked raw fruits and vegetables. ²
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brush your teeth with a soft toothbrush at least twice a day. ² Floss daily if it is your normal routine and tolerated.
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take daily showers or baths if able (otherwise sponge bath daily). ²
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Check your mouth and your skin for potential sites of infection (e.g., access devices, rectal area) and keep these areas clean and dry. ²

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies
- Patient agrees to try self-care items #: _____
How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
- Patient agrees to seek medical attention; specify time frame: _____
- Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) NCCN 2023; 2) BCCA 2018; 3) ONS 2019; 4) NICaN 2022... (pages 42-55 for all references).

Mouth Dryness/Xerostomia Practice Guide

Xerostomia: abnormal dryness in the oral cavity due to a reduction and/or thickening of saliva produced; the subjective experience of dry mouth secondary to salivary gland hypofunction; may be acute or chronic.¹⁻⁵

1. Assess severity of the dry mouth^{1-4,6-11}

What number from 0 to 10 best describes your dry mouth where 0= "no dry mouth" and 10= "worst possible dry mouth"? ^{1,2,12}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your dry mouth? ^{1,2}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Is your saliva thick or less saliva than normal? ^{1,2,4,13}	No/A bit ^{G1}	<input type="checkbox"/>	Somewhat ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
→ Do you have (signs of sicca syndrome): ⁷⁻¹¹ <input type="checkbox"/> abrupt onset of dry mouth, <input type="checkbox"/> thick saliva, <input type="checkbox"/> saliva pooling on the floor of your mouth, <input type="checkbox"/> dry eyes?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is your mouth painful? ^{1,2,4,7}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you see any redness, white patches, cracks, or blisters in your mouth? ^{1,2,4,7}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever >38°C? ^{1,2} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is your mouth bleeding? ²	No	<input type="checkbox"/>	Yes, with eating or oral hygiene	<input type="checkbox"/>	Yes, spontaneously	<input type="checkbox"/>
Are you able to eat? ^{1,2,6}	Yes ^{G1}	<input type="checkbox"/>	Yes, soft food ^{G2}		No ^{G≥3}	<input type="checkbox"/>
→ Are you able to eat? ⁷	Yes, all foods	<input type="checkbox"/>	Yes, most foods	<input type="checkbox"/>	No or soft foods only	<input type="checkbox"/>
How much fluid are you drinking per day? ^{1,2,7}	6-8 glasses	<input type="checkbox"/>	1-5 glasses		Sips/Unable to swallow	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{1-3,7}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Do you have (signs of diabetic ketoacidosis): ⁷ <input type="checkbox"/> increased thirst, <input type="checkbox"/> frequent urination, <input type="checkbox"/> fruity breath odour <input type="checkbox"/> stomach pain, <input type="checkbox"/> weakness, <input type="checkbox"/> fast heart rate <input type="checkbox"/> vomiting, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of uveitis): ^{7,9,10} <input type="checkbox"/> dry eyes, <input type="checkbox"/> eye pain, <input type="checkbox"/> eye redness, <input type="checkbox"/> blurred/ double vision, <input type="checkbox"/> new floaters, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> eyelid swelling, <input type="checkbox"/> change in colour vision?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your dry mouth affect your ability to speak? ^{1,2,4,6}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you having taste changes? ^{1,2,4,6}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Have you lost weight in the last 1-2 weeks without trying? ^{1,2} Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
Do you have trouble breathing? ¹	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you taking any medications that can cause dry mouth? ^{1-4,11} (e.g., anticholinergics, antiemetics)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does your dry mouth affect your daily activities? ^{1,2,6}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Are you feeling worried? ^{1,2} If yes, see Anxiety guide.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity^{1,7}

Review self-care
 Verify medications

Review self-care
 Verify medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

Refer for medical attention immediately and alert if on immunotherapy.

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for dry mouth, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-4,6,7,9,11}

Current use	Examples of medications for dry mouth	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Saliva substitutes (Biotene [®] , Moi-Stir [®]) ^{1-4,6,7}		Expert opinion
<input type="checkbox"/>	Pilocarpine (Salagen [®]) saliva stimulant ^{2-4,7,9,11}		Expert opinion
<input type="checkbox"/>	Anetholtrithion (Sialor [®]) salivary stimulant ¹		Expert opinion
<input type="checkbox"/>	Oral medications for pain ^{1,2,7}		Expert opinion

*Older adults may be more sensitive to the side effects of pilocarpine.³

4. Discuss self-care strategies^{1-7,14}

- **What helps** when you have a dry mouth?^{1,2} Reinforce as appropriate. Specify:
- What is your **goal** for managing your dry mouth?^{1,2}
- Would **more information** about your symptoms help you to manage them better?³ If yes, provide relevant information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink 6-8 glasses of clear fluids per day. ^{1,2,4,7,14}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid foods and drinks that are highly acidic, caffeinated, sugary, salty, spicy, or very hot (temperature). ^{1-4,7}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have difficulty swallowing, eat a soft diet . ^{1,2,4,7} Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes. Add extra moisture to foods using sauce, dressing, gravy, broth, or butter/margarine.
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Keep your mouth cool and moist with fresh, cold foods. ^{1,2,7,14} Suggest sugar-free popsicles, frozen grapes, cold water, or ice cubes.
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brush your teeth at least twice a day using a soft toothbrush and fluoride toothpaste. Floss daily if it is your normal routine and tolerated. ^{1,2,4,14}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you wear dentures, remove before brushing your teeth, cleaning them with toothpaste, and leave them off for long periods of time (e.g. overnight). ^{1,2,4,14}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use a bland rinse 4 times/day . ^{1-4,14} For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. Prepare daily.
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chew on sugar-free gum or sucking on hard candy to help create saliva. ^{1-4,6,7,14} Xylitol gum or lozenges can also be used, up to 6 grams a day.
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid tobacco and alcohol , including alcohol-based mouthwashes. ^{1-4,14}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use moisturizers or lip balm to protect your lips. ^{1-4,14}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use saliva substitutes (gel, mouthwash, spray). ^{1-4,6,7,14} If already using, how long have you been using them, and do they help? Discourage use of glycerin-based swab sticks.
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use a cool humidifier or bedside vaporizer to help reduce the dryness. ^{1,3}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consider trying acupuncture therapy. ^{1,4,5}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:	
<input type="checkbox"/>	Referral (service & date): _____	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____	
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date

References: 1) BCCA 2019; 2) CCO 2021; 3) AHS 2019; 4) NCI 2024... (pages 42-55 for all references).


Mouth Sores/Stomatitis Practice Guide

Mouth sores/Stomatitis/Oral Mucositis: An inflammatory and potentially ulcerative process of the mucous membranes, that can result in severe discomfort that can impair patients' ability to eat, swallow, and talk, and is accompanied by a risk for life-threatening bacteremia and sepsis.¹⁻⁹

1. Assess severity of the mouth sores^{1-5,10-17}

What number from 0 to 10 best describes your mouth sores where 0= "no mouth sores" and 10= "worst possible mouth sores"? ^{2,10,11,18}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your mouth sores? ^{2,10,11}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How many sores/ulcers/blisters do you have? ^{1-3,5,10,11}	0-4	<input type="checkbox"/>	>4	<input type="checkbox"/>	Coalescing/ Merging/Joining	<input type="checkbox"/>
Do the sores in your mouth bleed? ^{1,2,10,11}	No	<input type="checkbox"/>	Yes, with eating or oral hygiene	<input type="checkbox"/>	Yes, spontaneously	<input type="checkbox"/>
Are the sores painful? ^{1-5,10,11,19}	No/Mild ^{G1} 0-3	<input type="checkbox"/>	Moderate ^{G2} 4-6	<input type="checkbox"/>	Severe ^{G≥3} 7-10	<input type="checkbox"/>
Do you see any redness or white patchy areas in your mouth? ^{2,3,10,11}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Do you have (signs of skin toxicity): ¹²⁻¹⁷ <input type="checkbox"/> sores/ulcers/blisters in your mouth, <input type="checkbox"/> redness or white patchy areas in your mouth, <input type="checkbox"/> irritated gums and/or throat?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ^{2,10,11} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a dry mouth? ^{2,3,10,11}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you able to eat? ^{1-4,10,11}	Yes	<input type="checkbox"/>	Yes, soft food	<input type="checkbox"/>	No	<input type="checkbox"/>
→ Are you able to eat? ¹²	Yes, all foods	<input type="checkbox"/>	Yes, most foods	<input type="checkbox"/>	No or soft foods only	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine, dark urine? ^{2,3,10,11}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
How much fluid are you drinking per day? ^{2,3,10,11}	6-8 glasses	<input type="checkbox"/>	1-5 glasses		Sips/Unable to swallow	<input type="checkbox"/>
Have you lost weight in the last 1-2 weeks without trying? ^{1,2,10,11} Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
Are you having trouble breathing? ²	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Does your mouth sore(s) affect your daily activities? ^{1,2,10,11}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>

 **1** Mild (Green)

 **2** Moderate (Yellow)

 **3** Severe (Red)

2. Triage patient for symptom management based on highest severity^{1-4,8,10-13}

Review self-care
 Verify medications

Review self-care
 Verify medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

Refer for medical attention immediately and alert if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for mouth sores, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-5,10,11}

Current use	Examples of medications for mouth sores	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzydamine hydrogen chloride (Tantum® mouth rinse) ^{1-4,10,11}		Likely effective
<input type="checkbox"/>	Dexamethasone mouthwash ^{1,10,11}		Likely effective
<input type="checkbox"/>	Oral medications, ^{2-5,10,11} morphine mouth wash, ^{4,10,11} topical anesthetics (lidocaine), ^{2,4,5,10,11} transdermal fentanyl ^{5,10,11} for pain		Expert opinion
<input type="checkbox"/>	0.5% Doxepin mouth rinse for pain ^{10,11}		Expert opinion
<input type="checkbox"/>	Mucosal coating agents for pain (Gelclair®) ^{2,3,5,11}		Expert opinion
<input type="checkbox"/>	Saliva substitutes (Biotene®, Moi-Stir®, Caphosol®) ^{2,3,10,11}		Expert opinion
<input type="checkbox"/>	Nystatin for oral candida ³		Expert opinion

* Some benzydamine HCl formulations contain alcohol and can cause stinging.^{3,4,10,11} Chlorhexidine mouth rinse and sucralfate are not recommended for treatment.^{1-3,10} "Magic" Mouthwash (mixed medication mouthwash) is not recommended for practice.^{1,2} Local anesthetics for short term pain relief can make it hard to swallow; if used patients should be advised about increased risk of choking when eating.² Advise not to swallow morphine mouthwash or lidocaine due to systemic side effects including fatal arrhythmia.²

4. Discuss self-care strategies^{1-11,20-23}

- **What helps** when you have mouth sores?^{2,10,11} Reinforce as appropriate. Specify:
- What is your **goal**?^{2,10,11}
- If eating is difficult, have you seen or **spoken to a dietitian** or tried meal supplements?^{2,3,10}
- Would **more information** about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.^{2,4,10}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use a bland rinse 4 times/day (more often if mouth sores). ^{1-3,5,10,11} For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. Prepare daily.
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Brush your teeth at least twice a day using a soft toothbrush (use soft foam toothette in salt/soda water if sores). Floss daily if it is your normal routine and tolerated. ^{1-3,5,6,10,11}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rinse your toothbrush in hot water before using and allow to air dry. ^{2,3,10,11}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you wear dentures , brush and rinse them after meals and at bedtime. Remove nightly and soak in a bland rinse. If mouth sensitive, use only at mealtimes . ^{2-4,10,11}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use moisturizers or lip balm to protect your lips. ^{2,3,10,11}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use lactobacillus lozenges ¹ or xylitol containing lozenges, gum, or popsicles. ^{10,11}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid tobacco and alcohol , including alcohol-based mouthwashes. ^{2-4,10,11}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink 6-8 glasses of fluids per day. ^{2,3,10,11}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat a soft diet . ^{2,4,10,11} Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes.
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If on pain medicine , try taking it before brushing teeth and eating . ^{2,10,11}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid foods/drinks that are acidic, salty, spicy, or very hot . ^{2,4,5,10,11}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During chemotherapy, take ice water or ice chips for 30 min. ^{1-7,9,10,20-22}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Consider using low level laser therapy. ^{8,22,23}

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #:
How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
- Patient agrees to use medication to be consistent with prescribed regimen. Specify:
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) ONS 2019; 2) BCCA 2019; 3) NICaN 2022; 4) AHS 2019; 5) NCI 2024... (pages 42-55 for all references).

Nausea & Vomiting Practice Guide

Nausea: A subjective perception that vomiting may occur. Feeling of queasiness.¹⁻³ Vomiting: A forceful expulsion of stomach contents through the mouth and may include retching/dry heaves (gastric and esophageal movement without vomiting).¹⁻³

1. Assess severity of nausea/vomiting¹⁻¹⁷

What number from 0 to 10 best describes how you are feeling 0= "No nausea" and 10= "Worst possible nausea" ^{1,4,18}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your nausea/vomiting? ²⁻⁸	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
If vomiting: How many times per day? ^{1,3-6,19}	≤1 ^{G1}	<input type="checkbox"/>	2-5 ^{G2}	<input type="checkbox"/>	≥6 ^{G≥3}	<input type="checkbox"/>
What is the amount of vomit? ^{1,4,5}	Small	<input type="checkbox"/>	Medium	<input type="checkbox"/>	Large	<input type="checkbox"/>
Is there any blood or look like coffee grounds? ^{1,4,5}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you been able to eat within last 24 hours? ^{1,2,4,5}	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Have you lost weight in the last 1-2 weeks without trying? ^{1,4}	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
How much fluid are you drinking per day? ^{1,2,4,5,9}	6-8 glasses	<input type="checkbox"/>	1 to 5 glasses	<input type="checkbox"/>	Sips	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{1,2,4,5,9}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have any abdominal pain? ^{1,3-5}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Does your nausea/vomiting affect your daily activities? ^{1,4}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Are you taking medicines that can cause nausea/ vomiting? ^{1-6,9} (e.g., opioids, antidepressants, antibiotics, warfarin)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have any other symptoms? ^{1-6,8,9} <input type="checkbox"/> Pain <input type="checkbox"/> Fever <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Anxiety <input type="checkbox"/> Headache	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ¹⁰⁻¹⁷ <input type="checkbox"/> fatigue/ weakness, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> headache, <input type="checkbox"/> appetite loss, <input type="checkbox"/> vision changes, <input type="checkbox"/> weight gain or loss, <input type="checkbox"/> constipation, <input type="checkbox"/> dizziness, <input type="checkbox"/> mood or behaviour changes, <input type="checkbox"/> decreased libido, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin, <input type="checkbox"/> hair loss, <input type="checkbox"/> feeling cold, <input type="checkbox"/> puffy face	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of autonomic neuropathy): ¹⁰ <input type="checkbox"/> constipation, <input type="checkbox"/> urinary problems, <input type="checkbox"/> sweating changes	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of aseptic meningitis): ¹⁰⁻¹⁷ <input type="checkbox"/> headache, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> neck stiffness, <input type="checkbox"/> low-grade fever	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ^{10-12,14-17} <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> appetite loss, <input type="checkbox"/> right side abdominal pain, <input type="checkbox"/> fatigue, <input type="checkbox"/> increase in bleeding/bruising	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of GI toxicity): ^{10,11,13-16} <input type="checkbox"/> abdominal pain, <input type="checkbox"/> diarrhea, <input type="checkbox"/> blood or mucus in stool, <input type="checkbox"/> fever, <input type="checkbox"/> weight loss	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hemolytic uremic syndrome): ¹⁰ <input type="checkbox"/> blood in urine/stool or nose/mouth, <input type="checkbox"/> less urine, <input type="checkbox"/> new/unexplained bruises, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> pale skin, <input type="checkbox"/> fatigue, <input type="checkbox"/> confusion/seizures, <input type="checkbox"/> swelling	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>

	Mild (Green)		Moderate (Yellow)		Severe (Red)
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2. Triage patient for symptom management based on highest severity^{1,2,4,5}

<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately and alert if on immunotherapy.
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Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for nausea/vomiting, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-9,20-23}

Current use	Examples of medications for nausea/vomiting*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	5-HT ₃ : ondansetron (Zofran®), granisetron (Kytril®), dolasetron (Anszemet®) ^{1-9,20-22}		Effective
<input type="checkbox"/>	Olanzapine (Zyprexa®) ^{1-4,6-9,20-23}		Effective
<input type="checkbox"/>	Fosaprepitant (Emend® IV), aprepitant (Emend®) ^{1-3,5-9,20-22}		Effective
<input type="checkbox"/>	Triple drug: ^{2,3,5-9,20-22} dexamethasone, 5 HT ₃ (palonosetron), neurokinin 1 receptor antagonist (netupitant) for high emetic risk		Effective
<input type="checkbox"/>	Cannabis/Cannabinoids ^{1-4,7-9,22}		Effective
<input type="checkbox"/>	Netupitant/palonosetron (NEPA) (Akynzeo®) ^{1-3,6-9,20,22}		Effective
<input type="checkbox"/>	Dexamethasone (Decadron®) alone or in combination ^{1-9,20-22}		Likely effective
<input type="checkbox"/>	Gabapentin (Neurontin®) ⁷		Likely effective
<input type="checkbox"/>	Progestins ⁷		Likely effective
<input type="checkbox"/>	Anticipatory: Lorazepam (Ativan®), haloperidol (Haldol®) ^{1-9,20,22}		Expert opinion
<input type="checkbox"/>	Metoclopramide (Maxeran®), prochlorperazine (Stemetil®) ^{1-6,9,20,22}		Expert opinion
<input type="checkbox"/>	Other: Cyclizine, ^{5,6} dimenhydrinate, ^{1,3,4,8} methotrimeprazine ¹		Expert opinion

*Patients are at increased risk of opioid overdose and serious side effects when taking gabapentin with an opioid.²⁴ Rectal administration should be avoided if neutropenic.

4. Discuss self-care strategies^{1-9,20,22,25}

- **What helps** when you have nausea/vomiting?^{1,4} Reinforce as appropriate. Specify:
- What is your **goal**?^{7,9}
- Have you seen or spoken to a **dietitian**?^{1,4,9}
- Would **more information** about your symptoms help you to manage them better?^{1,4} If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drink 6-8 glasses of clear fluids per day. ^{1,4,9}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use relaxation techniques (e.g., guided imagery, progressive muscle relaxation, hypnosis, music therapy). ^{1,4,6-9,22}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take fast-acting anti-emetics (e.g., ondansetron (Zofran®), granisetron (Kytril®), dolasetron (Anszemet®) 30-60 minutes before meals so they are effective during/after meals. ^{1,4}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If vomiting, limit food and drink until vomiting stops . After 30-60 min without vomiting, sip clear fluids. When clear fluids stay down, add dry starchy foods (crackers, dry toast, dry cereal, pretzels). If starchy foods stay down, add protein rich foods (e.g., eggs, chicken). ^{1,4}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If nausea, eat small, frequent meals and snacks . ^{1,4,9} Eat foods that reduce your nausea and are your “comfort foods” cold or room temperature. ^{1,4,9} Avoid greasy/fried, highly salty, spicy, and foods with strong odors. ^{1,4,9} Avoid tobacco and alcohol. ^{1,6,9}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sit upright or recline with your head raised for 30-60 minutes after meals. ^{1,4}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If vomiting, use a bland rinse 4 times/day . ⁴ For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. Prepare daily.
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try acupressure (e.g., acupressure bracelet) or acupuncture . ^{1,4,9,22,25}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____
<input type="checkbox"/>	Referral (service & date): _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur
Name	Signature
	Date

References: 1) BCCA 2018; 2) NCI 2023; 3) INESSS 2020; 4) CCO 2019... (pages 42-55 for all references).

Pain Practice Guide

Pain: subjective sensory or emotional discomfort associated with actual or potential tissue damage or described in terms of such damage.¹⁻⁸

1. Assess the pain and severity^{1-7,9-25}

Tell me about the pain (location, onset, radiating, what does it feel like, what makes it better or worse):^{1-7,9-15} _____

Do you know what may be causing the pain (surgery, injury, illness, pre-existing pain/arthritis, spinal cord compression)?^{1,2,4-7,9-13,16}

What number from 0 to 10 best describes your level of pain where 0="No pain" and 10="Worst possible pain" ^{1,2,6,7,9-17,26}	0 – 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Rating of worst pain and pain 2hr after medicine? ^{1,2,9,11,14}	0 - 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Are you able to easily distract yourself from the pain? ¹¹	Yes, often	<input type="checkbox"/>	Yes, sometimes	<input type="checkbox"/>	No, never	<input type="checkbox"/>
Are you worried about your pain? ^{1,2,5,6,11,12}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Did the pain start suddenly? ^{1-3,6,7,9-14}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is the pain from a new location? ^{1,2,6,7,9-11,13} Describe.	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have loss of bladder or bowel control, numbness in your fingers, toes or bum, feel unsteady on your feet, or difficulty walking? ^{1,6}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you feel confused, very sleepy, nauseous, hallucinate, or have muscle spasms? ^{1,2,6,7,9,11,12,15}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your pain interfere with your daily activities? ^{1,2,6,7,9-14,17,27}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Does your pain interfere with your mood? ^{1,2,6,9-11,13}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		<input type="checkbox"/>
Are you able to get pain relief from your medicines? ^{1,2,6,7,9-13}	Yes, relief	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	No	<input type="checkbox"/>
Do the pain medicines restrict your daily activities? ^{1,2,10,11,13,17}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have (risk factors for opioid misuse): ^{2,6,7,9-11,13,15,17} <input type="checkbox"/> past alcohol or drug misuse, <input type="checkbox"/> psychiatric disorder, <input type="checkbox"/> younger age, <input type="checkbox"/> legal problems, <input type="checkbox"/> past sexual abuse, <input type="checkbox"/> poor financial and/or social support <input type="checkbox"/> current heavy smoker?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have other symptoms: ^{1,2,4-6,11,12} <input type="checkbox"/> Constipation, <input type="checkbox"/> Nausea/Vomiting, <input type="checkbox"/> Depression, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Sleep changes, <input type="checkbox"/> Itchiness, <input type="checkbox"/> Peripheral neuropathy (hands, feet)	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of musculoskeletal toxicities): ¹⁸⁻²⁴ <input type="checkbox"/> joint pain/swelling, <input type="checkbox"/> stiffness after inactivity, <input type="checkbox"/> muscle weakness, <input type="checkbox"/> movement/heat improves pain	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ^{18,19,21-24} <input type="checkbox"/> yellow skin/ eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> right side abdominal pain <input type="checkbox"/> fatigue, <input type="checkbox"/> increase in bleeding/bruising	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ¹⁸⁻²⁵ <input type="checkbox"/> fatigue/weakness, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> appetite loss, <input type="checkbox"/> headache, <input type="checkbox"/> nausea/vomiting, <input type="checkbox"/> vision changes, <input type="checkbox"/> weight gain or loss, <input type="checkbox"/> constipation, <input type="checkbox"/> dizziness, <input type="checkbox"/> mood or behaviour changes, <input type="checkbox"/> decreased libido, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin, <input type="checkbox"/> hair loss, <input type="checkbox"/> feeling cold, <input type="checkbox"/> puffy face	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of ocular toxicity): ^{18-20,22,24} <input type="checkbox"/> dry eyes, <input type="checkbox"/> eye pain, <input type="checkbox"/> eye redness, <input type="checkbox"/> blurred/double vision, <input type="checkbox"/> new floaters, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> eyelid swelling, <input type="checkbox"/> change in colour vision	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity^{1,2,6,7,9-12,17,28}

Review self-care
 Review medications

Review self-care.
 Review medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.

Refer for medical attention immediately and alert if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for pain, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-7,9,11-24,28-32}

Current use	Examples of medications for pain (steps according to WHO)*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Step 1: Non-opioid: acetaminophen (Tylenol®), NSAIDs (Ibuprofen®), COX-2 inhibitors (Celebrex®), nefopam (Acupan®) ^{1-3,5-7,9,11-13,15-25,29,30}		Likely effective
<input type="checkbox"/>	Step 2: Weak opioid: codeine, tramadol, tapentadol ^{2,3,5-7,9,11-13,15,17,28-30}		Effective
<input type="checkbox"/>	Step 3: Strong opioid: morphine, oxycodone, fentanyl, hydromorphone ^{1,2,5-7,9,11-13,15-17,28-31}		Effective
<input type="checkbox"/>	Breakthrough pain: extra dose of immediate-release oral opioids or transmucosal fentanyl ^{1,2,6,7,9,11-17,29}		Effective
<input type="checkbox"/>	Chronic pain: Transdermal buprenorphine, transdermal fentanyl, systemic anesthetics (e.g., mexiletine) ^{1,2,5,7,9,12,13,15,17}		Effective
<input type="checkbox"/>	Chronic pain: Cannabis/Cannabinoids ^{1,2,5,7,11}		Likely effective
<input type="checkbox"/>	Refractory pain: Ketamine ^{4,6,7,13,30}		Benefits balanced with harm
<input type="checkbox"/>	Neuropathic pain: Antidepressant or anticonvulsant ^{2,3,5-7,9,11,12,16-18,20,23,24,29,32}		Likely effective
<input type="checkbox"/>	→ Prednisone for immunotherapy-related pain ¹⁸⁻²⁴		Expert opinion
<input type="checkbox"/>	Constipation prophylaxis: stimulant (sennosides or bisacodyl) plus osmotic laxative (lactulose or PEG) ^{1,2,6,7,9,11-13,15,17,29}		Likely effective/ expert opinion

*Use NSAIDs with caution due to risk of renal, GI, or cardiac toxicities, thrombocytopenia, or bleeding disorder.^{2,6,7,9,11,18-20,24,28} Avoid use of long-acting opioids during severe acute pain. Use opioids with caution in patients with kidney or liver dysfunction.^{1,2,6,7,9,11,12,15,17,29,30,32} Avoid tricyclic antidepressants in the elderly.^{2,6,11}

4. Discuss self-care strategies^{1-3,5-17,29,33-44}

- **What helps** when you have pain? Reinforce as appropriate.^{1,2,7,10-13}
- What is your **goal** for pain relief (e.g., target on scale of 0 to 10)?^{1,2,6,7,9-11,13-15}
- Do you understand the plan for **taking routine and breakthrough medicines** for pain? If no, educate about pain and pain management.^{1,2,5-7,9,11,15,17}
- Do you have any **concerns about taking pain medicines**? If yes, explore and educate.^{1-3,6,7,9,10,12,13,15}
- If you have other symptoms, are they under control?^{2,6,9}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Track your pain level when taking medicine and 1-2 hr. after. ^{1,2,12,15}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use medicines to prevent constipation if taking opioids. ^{1,2,6,7,9,11-13,15,17,29}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try massage (+/- aromatherapy), physio , acupressure , acupuncture , heat/cold, or transcutaneous electrical nerve stimulation. ^{1,2,6,8,11,16,33-36}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try light physical activity (walk, swim, cycle, stretch, yoga). ^{1,2,7,11,12,16,37-39}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try activities to help you cope with pain (e.g., listening to music, meditation, breathing exercises, activities for distraction, relaxation, mindfulness-based stress reduction, cognitive behavioural therapy (CBT), biofeedback, guided imagery, progressive muscle relaxation, hypnosis). ^{1-3,7,11,12,16,33,40-44}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Participate in patient and family counselling and/or rely on friends/family for support. ^{1,2,11,12}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not, 10=very)?
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) BCCA 2018; 2) NCCN 2023; 3-5) ONS 2019; 6) NCI 2024; 7) AHS 2018... (pages 42-55 for all references).

Peripheral Neuropathy Practice Guide

Neuropathy: Numbness, tingling, burning, pins and needles, tremor, balance disturbances, pain in hands, feet, legs or arms. The end result of peripheral, motor, sensory, and autonomic neuron damage caused by neurotoxic chemotherapy agents that inactivate the components required to maintain the metabolic needs of the axon.¹⁻¹⁰ Other causes of peripheral neuropathy include surgical trauma, treatment with immune checkpoint inhibitors, and radiation involving the spine.^{1,3,8}

1. Assess severity of the neuropathy^{1-8,11-17}

If receiving chemotherapy, what was the date of your last treatment? _____

Tell me about the neuropathy (location, onset, radiating, what does it feel like, what makes it better or worse):^{1,3,5-7}

What number from 0 to 10 best describes your neuropathy where 0="No neuropathy" and 10="Worst possible neuropathy" ^{1,3-7,18}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your neuropathy? ⁸	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have pain in your _____ (neuropathy location)? ^{1-5,7}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
→ Pain in lower back or thighs ^{8,11,12}	No 0	<input type="checkbox"/>	Mild 1-3	<input type="checkbox"/>	> Moderate 4-10	<input type="checkbox"/>
Do you have new weakness in your arms or legs? ^{1,2,7}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Rapid onset of weakness in arms or legs ^{8,12-16}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you noticed problems with your balance or how you walk or climb stairs? ^{1,2,5,7} If yes, how much?	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Are you constipated? ^{1,2,5}	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have difficulty emptying your bladder of urine? ^{1,5}	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Constipation or urinary problems ^{8,11,14}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your neuropathy/numbness/tingling affect your daily activities? (e.g., buttoning clothing, writing, holding coffee cup)? ^{1,5-7,19}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
→ Neuropathy interferes with daily activities ^{8,11,13-17}	No ^{G1}	<input type="checkbox"/>			Yes ^{G≥2}	<input type="checkbox"/>
→ Do you have: <input type="checkbox"/> Difficulty walking, <input type="checkbox"/> Double vision, <input type="checkbox"/> Facial weakness, <input type="checkbox"/> Drooping eyelid(s), <input type="checkbox"/> Breathlessness, <input type="checkbox"/> Swallowing or speaking problems, <input type="checkbox"/> Nausea, <input type="checkbox"/> Sweating changes? ^{8,11,13-15}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity^{1,3,5-8,11,13-17,20}

<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> Refer for medical attention immediately and alert if on immunotherapy.
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Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for neuropathy, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1-6,8-17,20-23}

Current use	Examples of medications for neuropathy*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Duloxetine ^{1-6,8-12,16,20-22}		Likely effective
<input type="checkbox"/>	Gabapentin (Neurontin®) and opioid combination ^{2,3,6,8}		Likely effective
<input type="checkbox"/>	Corticosteroids - prednisone/methylprednisolone ^{1,3,6,8,11-17}		Expert opinion
<input type="checkbox"/>	Anti-convulsants gabapentin, pregabalin (Lyrica®) ^{1,3-6,8,9,11,12,16,23}		Expert opinion
<input type="checkbox"/>	Tricyclic anti-depressants: amitriptyline (Elavil®), nortriptyline (Pamelor®), duloxetine (Cymbalta®), venlafaxine (Effexor®), bupropion (Wellbutrin®, Zyban®) ^{1,3-6,9,11,23}		Expert opinion
<input type="checkbox"/>	Opioids – fentanyl, morphine (Statex®), hydromorphone (Dilaudid®), codeine, oxycodone (OxyContin®), tapentadol (Nucynta®), methadone (Dolophine®) ^{1,3,5,9,21}		Expert Opinion
<input type="checkbox"/>	Topical – lidocaine patch 5% ^{1,3,5,6,9}		Expert Opinion

*Opioids combined with anticonvulsants or anti-depressants increase CNS adverse events requiring careful titration.²³ Avoid tricyclic antidepressants in the elderly.³⁻⁶ Carnitine/L-carnitine and human leukemia inhibitory factor are not recommended for practice.^{2,5,20}

4. Discuss self-care strategies^{1-3,5-7,9,10,21,22}

- **What helps** with managing your neuropathy?^{1,5,7} Reinforce as appropriate.
- What is your **goal**?^{1,3,5,7}
- Have you seen or spoken to a doctor, nurse practitioner, or pharmacist about the peripheral neuropathy?^{1,3}
- Have you seen or spoken to a **physiotherapist** about: A walker, cane, or splint to help with balance and improve walking,^{1-3,5-7} physical training plan,^{1-3,9,10} or transcutaneous electrical nerve stimulation (TENS)?^{1,3,5,10}
- Have you seen or spoken to an **occupational therapist** about using loafer-style shoes or Velcro shoe laces,¹ adaptive equipment (e.g., larger handles on eating utensils)?⁵
- Would **more information** about your symptoms help you to manage them better?¹ If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Look at your hands and feet every day for sores/blisters that you may not feel. ¹ Talk to your doctor or nurse practitioner if the sores/blisters do not heal.
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy in feet: Wear footwear that fits you properly and avoid going barefoot. ^{1,2,5}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuropathy in hands: Wear gloves when cooking, using oven, or doing dishes. ^{1,2}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In your home: ensure the walkways clear of clutter. ¹ Use a skid-free shower or bath mat in your tub. ^{1,2} Remove throw rugs that may be a tripping hazard. ^{1,2}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When walking on uneven ground , try to look at the ground to help make up for the loss of sensation in your legs or feet. ¹
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If any neuropathy, to avoid burns: Lower the temperature of your hot water heater. Use a thermometer to ensure shower or tub water is <110°F/43°C. ^{1,2}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid exposing your fingers and toes to very cold temperatures. ¹
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try dangling your legs before you stand up to avoid feeling dizzy. ¹
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For constipation , try eat a high-fiber diet and drink adequate fluids. ^{1,3}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For urinary issues, try to empty bladder at same time every day, bladder re-training exercises, and drink adequate fluids. ¹
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try acupuncture , acupressure, massage, yoga, relaxation therapy, or guided imagery. ^{1,3,5,6,21,22}

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #:
How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
- Patient agrees to use medication to be consistent with prescribed regimen. Specify:
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) BCCA 2018; 2) ONS 2019; 3) NCCN 2023; 4) CCO 2018; 5) AHS 2019... (pages 42-55 for all references).

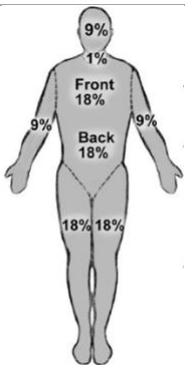
Skin Rash Practice Guide

Skin rash/alteration: A change in the colour, texture or integrity of the skin.¹⁻¹⁰

This practice guide is intended for any rash except for skin changes from radiation reaction. If the rash is in the radiation therapy area, refer to the Skin Reaction to Radiation practice guide.

1. Assess severity of the skin rash¹⁻¹⁶

Tell me about the skin rash (e.g., location, onset, what does it look like):^{11,13} _____

What number from 0 to 10 best describes your skin rash where 0="No skin rash" and 10="Worst possible skin rash" ^{13,17}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>															
Are you worried about your skin rash? ¹³	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>																	
Is the skin rash on one small part of your body (localized) or does it cover other areas (generalized)? ^{5-7,11,13,18}																					
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 20%;">Adult Body Part</th> <th style="width: 20%;">% of total BSA</th> </tr> <tr> <td>Arm</td> <td>9%</td> </tr> <tr> <td>Head</td> <td>9%</td> </tr> <tr> <td>Neck</td> <td>1%</td> </tr> <tr> <td>Leg</td> <td>18%</td> </tr> <tr> <td>Anterior trunk</td> <td>18%</td> </tr> <tr> <td>Posterior trunk</td> <td>18%</td> </tr> </table>	Adult Body Part	% of total BSA	Arm	9%	Head	9%	Neck	1%	Leg	18%	Anterior trunk	18%	Posterior trunk	18%		<10% BSA ^{G1}	<input type="checkbox"/>	10-30% BSA ^{G2}	<input type="checkbox"/>	>30% BSA ^{≥3}	<input type="checkbox"/>
Adult Body Part	% of total BSA																				
Arm	9%																				
Head	9%																				
Neck	1%																				
Leg	18%																				
Anterior trunk	18%																				
Posterior trunk	18%																				
➔ Is the skin rash localized or generalized? ^{1-4,8-10,12,15,16}			<10% BSA ^{G1}	<input type="checkbox"/>	>10% BSA ^{G≥2}	<input type="checkbox"/>															
Do you have any open wounds or blisters? ^{1,3-8,15,16}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>															
Do you have pain or feel burning at the skin rash area? ^{1,2,5-7,11,13}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>															
Is the rash itchy? ¹⁻¹⁶	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>																	
Does the affected area feel tight or swollen? ^{1-4,10,11,13}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>																	
Have you ever had a rash like this before? ^{1-3,9,14-16}	No/controlled with treatment	<input type="checkbox"/>			Yes, did not respond to treatment	<input type="checkbox"/>															
Does your skin rash affect your daily activities? ^{1-9,11-15}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>															
	1	Mild (Green)	2	Moderate (Yellow)	3	Severe (Red)															
2. Triage patient for symptom management based on highest severity^{1-12,14-16}	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 weeks.		<input type="checkbox"/> Refer for medical attention immediately and alert if on immunotherapy.																

Legend: ➔ Immune Checkpoint Inhibitor therapy; BSA=Body surface area; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for skin rash, including prescribed, over the counter, traditional medicines, and/or herbal supplements¹⁻¹⁶

Current use	Examples of medications for skin rash	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Topical corticosteroids (hydrocortisone, betamethasone, clobetasol propionate) ¹⁻¹⁶		Expert opinion
<input type="checkbox"/>	Antihistamines or antipruritics (hydroxyzine diphenhydramine, cetirizine, loratidine) ^{1-5,8-10,12,14,15}		Expert opinion
<input type="checkbox"/>	Oral corticosteroids (prednisone, methylprednisolone) ^{1-12,14-16}		Expert opinion
<input type="checkbox"/>	Antibiotics for infection, or prophylaxis ^{4-7,11-13,15}		Likely effective
<input type="checkbox"/>	Prophylaxis: Vitamin K cream ⁵		Expert opinion

*Low-dose corticosteroid cream should be used sparingly.¹ Higher potency topical steroids are preferred for short-term use (days to a few weeks) for immune-related dermatitis, compared to longer term use (several weeks to months) of lower potency steroids.²

4. Discuss self-care strategies¹⁻¹⁶

- **What helps** when you have a skin rash?^{9,13} Reinforce as appropriate.
- What is your **goal**?
- Have you seen or spoken to a **dermatologist**?^{1,2,4,7-9,11-16}
- Would **more information** about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid sun and protect your skin with sunscreen and clothes. ^{3-8,12-14}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid skin irritants (e.g., alcohol or perfume based creams, over the counter acne medications, clothes washed in scented laundry soap, tight fitting clothes or irritating fabrics like wool). ^{1,3,5-7,9,13,14}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use moisturizing cream on your skin (e.g., urea-based) daily. ^{1,3-6,8-15}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use oatmeal baths if itchy. ⁴
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take warm showers using mild non-scented soap . ^{5-7,12,13} Avoid hot water and bathing too long.
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use a cool compress for itchy skin. ⁴

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 1-2 weeks if no improvement, symptom worsens, or new symptoms occur ¹

Name	Signature	Date
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References: 1) ASCO 2021; 2) NCCN 2023; 3) ESMO 2022; 4) CCO 2018... (pages 42-55 for all references).

Skin Reaction to Radiation Practice Guide

Skin reaction/alteration: A change in the colour, texture or integrity of the skin. Radiation-induced skin reactions can vary from redness and skin darkening that usually progresses to dry peeling causing itchiness and thin skin. Open sores may weep causing wetness.^{1,2}

1. Assess severity of the skin reaction to radiation¹⁻¹²

Site of skin reaction(s)³ _____ Size of skin reaction(s)³ _____

What number from 0 to 10 best describes your skin reaction where 0="No skin reaction" and 10="Worst possible skin reaction" ^{3,13}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your skin reaction?	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Is your skin red? ^{1-3,5-10}	None	<input type="checkbox"/>	Faint/dull	<input type="checkbox"/>	Tender/bright, necrotic	<input type="checkbox"/>
Is your skin peeling/flaking? ^{1-3,6-8,14}	No/Dry ^{G1}	<input type="checkbox"/>	Patchy, moist ^{G2}	<input type="checkbox"/>	Generalized, moist ^{G3}	<input type="checkbox"/>
Do you have any swelling around the skin reaction area? ^{1,3,6,8}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, pitting edema	<input type="checkbox"/>
Do you have pain at the skin reaction area? ^{1-3,5-7,10-12}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you feel itchy at the skin reaction area? ^{1,3,5,6,10-12,14}	No/Mild ^{G1}	<input type="checkbox"/>	Yes, often ^{G2}	<input type="checkbox"/>	Yes, constant ^{G3}	<input type="checkbox"/>
Do you have any open, draining wounds? ^{1,3,5,6,8}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is there any odour from the skin reaction area? ^{1,3}	No	<input type="checkbox"/>			Yes, strong/foul	<input type="checkbox"/>
Do you have any bleeding? ^{3,5}	No	<input type="checkbox"/>			Yes, from minor trauma	<input type="checkbox"/>
Do you have a fever > 38° C? ³ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you started a new medication? ³	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does your skin reaction affect your daily activities? ^{2-5,7,9,11,12}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
		Mild (Green)		Moderate (Yellow)		Severe (Red)
2. Triage patient for symptom management based on highest severity^{3,5-7}	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		<input type="checkbox"/> Refer for medical attention immediately.	

Legend: NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional Comments:

3. Review medications patient is using for skin reaction, including prescribed, over the counter, traditional medicines, and/or herbal supplements^{1,3-7,10-12}

Current use	Examples of medications for skin reaction to radiation therapy*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Low-dose corticosteroid cream ^{1,3-7,10}		Likely effective
<input type="checkbox"/>	Infection: Silver Sulfadiazine (Flamazine) ^{1,3,4}		Likely effective
<input type="checkbox"/>	Open areas: Hydrocolloid & hydrogel Dressings ^{1,3-5}		Expert opinion
<input type="checkbox"/>	Moist desquamation: Silicone Dressings ^{1,3,4,6,7}		Expert opinion
<input type="checkbox"/>	Infection: Topical antibiotics ^{1,3,6}		Expert opinion

*Insufficient evidence to support or refute other agents for skin reaction (i.e., sucralfate cream,⁴ chamomile cream,⁴ oral antihistamines,⁴ emu oil,^{4,5} oral curcumin,^{4,11} specialty non-steroidal creams (e.g., Cavilon)^{4,5,7}). Low-dose corticosteroid cream should be used sparingly on intact skin.^{1,3,6,7} Silver sulfadiazine (**Flamazine**) should not be used if allergy to sulfa, history of severe renal or hepatic disease or during pregnancy.³ Hydrocolloid & hydrogel dressings are not advised for infected wounds and wounds with heavy exudate, or applied directly prior to treatment.^{1,3} Trolamine (Biafine®),^{4,5,7,12} calendula ointment,^{4,5} and aloe vera^{1,4,5,7} are not recommended for radiation skin reaction.

4. Discuss self-care strategies^{1-6,8,9}

- **What helps** when you have a skin reaction?³ Reinforce as appropriate.
- What is your **goal**?³
- Would **more information** about your symptoms help you to manage them better?^{1,3,6} If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Take lukewarm/tepid showers or baths using mild non-perfumed soap, and patting dry (no rubbing). ^{1,3,8,9}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid petroleum jelly , alcohol-based, and perfumed products. ^{1,3,4,6} Use non-scented creams on intact skin. ^{1,3,5,6,8}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wear loose clothes (e.g., soft breathable fabric like cotton). ^{1,3,8,9}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use deodorant on intact skin only. ^{1,3,5,8} Stop using if skin becomes irritated, blisters, or peels.
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use an electric razor instead of a wet razor for shaving. ^{1,3} Stop shaving if area becomes irritated.
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid waxing or other hair removal creams. ³
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid talcum powder, baby powder, and cornstarch especially on treatment areas. These products promote fungus growth and infections. ^{1,3}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shower after swimming in pools and lakes. Avoid swimming if skin is blistered, peeling or irritated. ^{1,3,8}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid temperature extremes (e.g., ice pack or heating pad) to the reaction area. ^{1,3} Protect the treatment area from the sun and the cold . ^{3,8}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use warm or room temperature normal saline compresses up to 4 times a day if the reaction area is itchy. ^{1,3}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid trauma to the treatment area by not using tape or Band-aids, not rubbing or scratching your skin, and opting to wear loose fitting clothing. ^{1,3}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat a well-balanced diet that includes fruit, vegetables, whole grains, and lean protein and drink fluids, 6-8 glasses per day. ^{1,3,8}

5. Document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) CCMB 2018; 2) Aguiar 2021; 3) BCCA 2018; 4) MASCC 2023... (pages 42-55 for all references).

Sleep Changes Practice Guide

Sleep changes: actual or perceived changes in night sleep resulting in daytime impairment.¹⁻⁴

1. Assess severity of the sleep changes¹⁻⁵

What number from 0 to 10 best describes how much your sleep changes affect your daytime activities at home and work where 0 = “No problems” and 10 = “Worst possible problems” ^{1,2,4-6}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your sleep changes? ^{1,2,4,5}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have difficulty falling asleep? ^{1,2,4,5}	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>	Takes ≥30 min every night	<input type="checkbox"/>
Do you have difficulty staying asleep? ^{1,2,4,5}	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>	Takes ≥30 min every night to go to sleep again	<input type="checkbox"/>
Do you have early morning waking when not desired? ^{1,2,4,5}	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>		
How long have these sleep changes been present? ^{2,4,5} Describe the sleep pattern change.	Less than 1 month	<input type="checkbox"/>	More than 1 month	<input type="checkbox"/>		
Did the onset of this problem occur with another issue? ¹⁻⁵ Describe.	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking any medicines that affect sleep (e.g., opiates, steroids, sedatives, etc.) ²⁻⁵	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have other sleep disorders (e.g., loud snoring, choking/gasping, sleep apnea, restless movement, restless legs)? ¹⁻⁵	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have other symptoms: ¹⁻⁵ <input type="checkbox"/> fatigue, <input type="checkbox"/> pain, <input type="checkbox"/> nausea, <input type="checkbox"/> anxiety, <input type="checkbox"/> depression, <input type="checkbox"/> hot flashes, <input type="checkbox"/> itchy skin, <input type="checkbox"/> breathlessness	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity^{1-3,5}

Review self-care.
 Verify medications

Review self-care.
 Verify medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 2-3 days.

Review self-care (If ≥30 minutes see 4.12).
 Verify medication use, if appropriate.
 For other sleep disorders, refer to sleep disorder clinic.

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional Comments:

3. Review medications patient is using for sleep changes, including prescribed, over the counter, traditional medicines, and/or herbal supplements¹⁻⁴

Current use	Examples of Medications for sleep changes*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®) ²⁻⁴		Expert opinion
<input type="checkbox"/>	Non-benzodiazepine Hypnotics - Zolpidem (Ambien®) ¹⁻⁴		Expert opinion
<input type="checkbox"/>	Tricyclic Antidepressants - Amitriptyline (Elavil®) ²⁻⁴		Expert opinion
<input type="checkbox"/>	Neuroleptics - Chlorpromazine (Thorazine®), Ormazine® ^{2,4}		Expert opinion
<input type="checkbox"/>	Herbal supplements (Melatonin, Kava, Valerian) ²⁻⁴		Expert opinion
<input type="checkbox"/>	Melatonin receptor agonists - Ramelteon (Rozerem®) ⁴		Expert opinion
<input type="checkbox"/>	Trazadone (Desyrel®) ²⁻⁴		Expert opinion
<input type="checkbox"/>	Antihistamines: Diphenhydramine (Benadryl®), Hydroxyzine (Atarax®) ^{2,4}		Expert opinion
<input type="checkbox"/>	Antipsychotics - Quetiapine (Seroquel®) ²⁻⁴		Expert opinion

*Medications for sleep changes should be short term (7-10 days) and depends on side effect profiles of the medicine and the potential for interaction with other current medications; need to balance benefits with harms.¹⁻⁴ Tricyclic antidepressants should be avoided in the elderly.² Antipsychotics are a last option.^{2,4}

4. Discuss self-care strategies^{1-5,7-14}

- **What helps** when you have problems sleeping?^{2,5} Reinforce as appropriate.
- What is your **goal** for sleeping (is it realistic e.g., 6 -10 hours sleep/night)?^{2,5}
- If you have **other symptoms**, are they under control?^{2,3,5}
- Do you understand the **effect of some medications on sleep**?^{2,3,5} Provide education.
- Would **more information** about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Track your sleep patterns in a diary . ^{1,2,5}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to go to sleep and wake at the same time each day. ¹⁻⁵
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to get exposed to light soon after waking and see if it affects your sleep. ^{1,2,4,5}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to clear your head early evening (problem solve, write down plan). ^{1,2,4,5,7}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have a 90-minute buffer zone before bedtime (e.g., read, watch TV, crossword puzzle, relax, listen to music, yoga, deep breathing, meditation, muscle relaxation/guided imagery, aromatherapy). ^{1-5,8,9}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Go to bed when you are sleepy . ^{1-3,5} If you can't fall asleep within 20-30 minutes, get out of bed and return when sleepy.
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Limit the use of the bedroom for sleep and/or sex . ^{1,2,5}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Restrict napping in the daytime. ¹⁻⁵ If needed, limit to one nap (20-30 minutes) and spend at least four hours awake before bedtime.
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have a comfortable sleep environment . ^{1-5,7} Suggest removing bedroom clock and avoid computer screens. If noisy or too bright, use ear plugs or eye masks .
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly. ^{1-5,7,10}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Limit caffeine after noon, limit smoking or alcohol, spicy or heavy meals, excessive fluids, intense activities close to bedtime. If you are hungry a protein snack is best. ^{1-4,7}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try a program like cognitive-behavioural therapy or personal counseling that provides more in-depth guidance on managing sleep changes. ^{1-5,11}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try acupressure or acupuncture. ^{7,12-14}

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #: _____
How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
- Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____
- Referral (service & date): _____
- Patient agrees to seek medical attention; specify time frame: _____
- Advise to call back in 2-3 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) ONS 2019; 2) BCCA 2019; 3) AHS 2019; 4) NCI 2024; 5) CCO 2022... (pages 42-55 for all references).

Swallowing Difficulty Practice Guide

Swallowing difficulty or dysphagia is the process of passing food or drink from the mouth through the esophagus to the stomach. It may also present as a sensation of food sticking in the throat or chest.¹

1. Assess severity of swallowing difficulty¹

Tell me what number from 0 to 10 best describes how difficult it is to swallow (0= no difficulty; 10= worst possible). ¹	0 – 3	<input type="checkbox"/>	4 - 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Are you worried about your difficulty swallowing? ¹	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How much have you had to eat or drink in the last 24 hours? ^{1,2}	Close to normal ^{G1}	<input type="checkbox"/>	About half my normal amount ^{G2}	<input type="checkbox"/>	Minimal to none ^{G3}	<input type="checkbox"/>
How long does it take for you to eat an average meal? ¹	< 30 minutes	<input type="checkbox"/>	About 30 minutes	<input type="checkbox"/>	>60 minutes or unable to swallow	<input type="checkbox"/>
Does food stick in your throat when you swallow? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Does swallowing take a great effort? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have difficulty swallowing pills? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you cough or choke when you eat?	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Have you lost weight because of swallowing problems? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you cough or choke when you drink liquids? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you gag or drool often? ¹	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Were you recently diagnosed with aspiration pneumonia? (fever, short of breath, feeling unwell, change in mucous amount/colour)? ¹	No	<input type="checkbox"/>		<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have any other symptoms? ¹ <input type="checkbox"/> mouth dryness, <input type="checkbox"/> anxiety	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity¹

Review self-care
 Verify medications

Review self-care
 Verify medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1 to 2 days

Refer for medical attention immediately.

Legend: NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for swallowing difficulty, including prescribed, over the counter, traditional medicines, and/or herbal supplements¹

Current use	Examples of medications for swallowing difficulty	Notes (e.g., dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Pain medicines 30-40 minutes before meals ¹		Expert opinion
<input type="checkbox"/>	Local anesthetic 5 to 10 minutes before eating if for painful swallowing ¹		Expert opinion

Local anesthetics for short term pain relief can make it hard to swallow; if used patients should be advised about increased risk of choking when eating.

4. Discuss self-care strategies¹

- **What helps** when you have difficulty swallowing?¹ Reinforce as appropriate. Specify:
- What is your goal?¹
- Have you seen or spoken to a **dietitian** or a speech language specialist?¹
- Would **more information** about your symptoms help you to manage them better?¹ If yes, provide relevant information or suggest resources.

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Here are some things that may be helpful...
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat foods that are easier to swallow (e.g., cooked extra soft foods, add extra sauces or gravy). ¹
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Avoid dry solid food , nuts, skins, leafy vegetables. ¹
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When eating and drinking, sit upright (90 degrees), limit distractions/talking, eat slowly with small bites or sips of fluids, swallow twice with each mouthful, take a sip of liquid to clear any food from sticking in your throat, and swallow hard with effort (by sitting comfortably with mouth relaxed, press tongue against roof of mouth as hard as possible, with tongue in position, press lips together and swallow as hard as possible). ¹
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to brush your teeth at least twice a day using a soft toothbrush (use soft foam toothette in salt/soda water if sores). Floss daily if it is your normal routine and tolerated. ¹
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Try to use a bland rinse 4 times/day (more often if mouth sores). For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. Prepare daily. ¹

5. Document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
- Patient agrees to use medication to be consistent with prescribed regimen Specify:
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to call back in 1 to 2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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References: 1) CCO 2021; 2) NCI-CTCAE 2017 (pages 42-55 for full references).

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