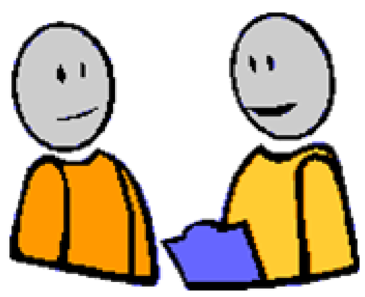

Remote Symptom Practice Guides
for
Adults on Cancer Treatments

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

October 2024

Summary of the changes to COSTaRS Practice Guides for the 2024 update

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Summary of the changes to COSTaRS Practice Guides for the 2024 update

- All 17 symptom practice guides were updated with the best available evidence from 175 guidelines and systematic reviews.

- A new practice guide was added for Swallowing difficulty.

- Section heading changes:
  - Section 3. Review medications: Added traditional medicines - “3. Review medications patient is using for [symptom], including prescribed, over the counter, **traditional medicines**, and/or herbal supplements”.
  - Section 4. Self-care strategies: Changed from “Review 3 or more self-care strategies” to “**Discuss** self-care strategies”.
  - Section 5. Documentation: Changed from: “Summarize and document plan agreed upon with patient” to “**Document** plan agreed upon with patient”.

- For the Medication section, the following definitions were added to the first section of the COSTaRS guides:

  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.

- The self-care strategies sections were re-formatted by moving discussion items to the top (e.g., “What helps when you feel [symptom]”?) leaving the specific strategies the patient can try in the table.

- A family caregiver participated on our Steering Committee, reviewed each practice guide, and provided valuable feedback to further help write them in plain language. A global change was to change the term “clinician” to “doctor or nurse practitioner”.

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)**

☐ Anxiety	☐ Depression	☐ Mouth sores/Stomatitis	☐ Skin Reaction to radiation
☐ Appetite Loss	☐ Diarrhea	☐ Nausea & Vomiting	☐ Sleep changes
☐ Bleeding	☐ Fatigue/Tiredness	☐ Pain	☐ Swallowing Difficulty
☐ Breathlessness	☐ Fever with Neutropenia	☐ Peripheral Neuropathy	☐ Other: ______________
☐ Constipation	☐ Mouth dryness/Xerostomia	☐ 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
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐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.

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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]

Question	1 – 3		4 - 6		7 - 10	
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	☐	4 - 6	☐	7 - 10	☐
Are you having panic attacks: ☐ periods/spells of sudden fear, ☐ discomfort, ☐ intense worry, ☐ uneasiness?[1-4,6,7]	No	☐	Yes, some	☐	Yes, many	☐
Does your anxiety affect your daily activities?[2-4,6,7,15]	Not at all[G1]	☐	Yes, some[G2]	☐	Yes, a lot[G≥3]	☐
Does your anxiety affect your sleep?[2-4,6]	Not at all	☐	Yes, some	☐	Yes, a lot	☐
Do any of these apply to you?[2-4,6,7] ☐ History of anxiety or depression, ☐ Lack of social support, ☐ Recurrent/advanced disease, ☐ Younger age, ☐ Substance use/withdrawal, ☐ Past trauma/abuse, ☐ Cognitive impairment, ☐ Difficulty communicating, ☐ Financial problems, ☐ Female, ☐ Dependent children, ☐ On steroids, ☐ Other health issues unrelated to cancer	No	☐	Yes, some	☐	Yes, many	☐
Do have any concerns that are making you feel more anxious?[2,6] ☐ Life events, ☐ Waiting for test results, ☐ New information about your cancer/treatment, ☐ Recently completed treatment, ☐ Spiritual/religious concerns?	No	☐	Yes, some	☐		
Do you have any other symptoms?[2,3,6] ☐ Fatigue, ☐ Breathlessness, ☐ Pain, ☐ Sleep changes	None	☐	Some	☐	Yes, many	☐
➔ Do you have (signs of hyperthyroidism):[8-13] ☐ weight loss, ☐ heart pounding or racing, ☐ tremors, ☐ feeling overheated, ☐ fatigue/weakness, ☐ diarrhea, ☐ swollen base of neck	No	☐			Yes	☐
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others?[2,6]	No	☐			Yes	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity[2,3,6,7]	☐ Review self-care ☐ Verify medications		☐ Review self-care ☐ Verify medications ☐ Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days		☐ If potential for harm, refer for further evaluation immediately ☐ If no, refer for non-urgent medical attention and alert if on immunotherapy. ☐ Review self-care. ☐ 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:

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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
☐	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®)[1-4,7]		Likely effective
☐	SSRIs/SNRIs - fluoxetine (Prozac®), paroxetine (Paxil®), citalopram (Celexa®), venlafaxine (Effexor XR®), sertraline (Zoloft®), escitalopram (Lexapro®), duloxetine (Cymbalta®)[2-4,7]		Likely effective
☐	Antipsychotics for treatment-resistant anxiety – Olanzapine (Zyprexa®), Risperidone (Risperdal®), Quetiapine (Seroquel®)[2-4,7]		Expert opinion
☐	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. ☐	☐	☐	**Physical activity** including yoga.[1,2,17]
2. ☐	☐	☐	Participate in **support groups** and/or rely on **family/friends** for support.[1-4,6,7]
3. ☐	☐	☐	**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. ☐	☐	☐	**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. ☐	☐	☐	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**

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

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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]

Question	Mild		Moderate		Severe	
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	☐	4-6	☐	7-10	☐
Are you worried about your lack of appetite?[2,7,8]	No/Some	☐	Yes, very	☐		
How much have you eaten in the past 24 hours (e.g., at each meal)?[2,3,7-9,18]	Less than normal[G1]	☐	Much less than normal[G2]	☐	Not eating at all[G≥3]	☐
Have you lost weight in the last 4 weeks without trying?[2,3,7-9] Amount: ☐Unsure	0-2.9%	☐	3-9.9%	☐	≥10%	☐
How much fluid are you drinking per day?[2,7]	6-8 glasses	☐	1-5 glasses	☐	Sips	☐
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]	☐	Yes, some [G1]	☐	Yes, a lot [G≥2]	☐
Is there anything causing your lack of appetite:[2,3,7,8] ☐ Recent surgery/treatment, ☐ New medication, ☐ Other	No	☐	Yes, some	☐	Yes, many	☐
Do you have any other symptoms?[2,3,7-9] ☐ Sore or dry mouth, ☐ Early fullness, ☐ Taste/smell changes, ☐ Nausea/ vomiting, ☐ Swallowing problems, ☐ Pain, ☐ Constipation, ☐ Diarrhea, ☐ Fatigue, ☐ Depression, ☐ Breathlessness	None	☐	Some	☐	Yes, many	☐
→ Do you have (signs of endocrine toxicity):[10-16] ☐ fatigue/weakness, ☐ abdominal pain, ☐ headache, ☐ nausea/vomiting, ☐ vision changes, ☐ weight gain or loss, ☐ constipation, ☐ dizziness, ☐ mood or behaviour changes, ☐ decreased libido, ☐ confusion, ☐ dry skin, ☐ hair loss, ☐ feeling cold, ☐ puffy face	No	☐			Yes	☐
→ Do you have (signs of renal toxicity):[11-14,16] ☐ decreased urine, ☐ blood in urine, ☐ swelling of hands or legs, face, abdomen, ☐ sudden weight gain, ☐ abdominal or pelvic pain, ☐ nausea/ vomiting, ☐ high blood pressure, ☐ drowsiness	No	☐			Yes	☐
→ Do you have (signs of hepatic toxicity):[10,11,13-16] ☐ yellow skin/eyes, ☐ dark urine, ☐ fever, ☐ nausea, ☐ right side abdominal pain, ☐ fatigue, ☐ increase in bleeding/bruising	No	☐			Yes	☐
Does your poor appetite affect your daily activities?[2,3,7-9]	No	☐	Yes, some	☐	Yes, a lot	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity[2,7,8]	☐ Review self-care ☐ Verify medications		☐ Review self-care ☐ Verify medications ☐ Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If severe loss of appetite is stabilized, review self-care strategies ☐ 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:

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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
☐	Corticosteroids[1-4,7-9] (dexamethasone (Decadron®), prednisone)		Likely effective
☐	Megestrol (Megace®)[1-3,7,8]		Benefits balanced with harms
☐	Omega 3 fatty acids (EPA, Fish Oil)[2,5,9,20]		Expert Opinion
☐	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. ☐	☐	☐	**Eat small frequent meals and snacks.**[2,3,7,8] Sitting upright for 30-60 min helps digestion.
2. ☐	☐	☐	**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. ☐	☐	☐	**Eat more** when you **feel most hungry.**[2,3]
4. ☐	☐	☐	**Eat foods that are higher in protein and calories.**[2,3,7-9]
5. ☐	☐	☐	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. ☐	☐	☐	Drink **higher energy and protein drinks** (Ensure, Glucerna).[1-3,7-9]
7. ☐	☐	☐	**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. ☐	☐	☐	Track your food, fluid intake and weight in a **diary.**[2,3,8,9]
9. ☐	☐	☐	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)

☐	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**

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 bleeding[1-11]

Where are you bleeding from?[1,2,11] ____________________

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

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3. Review medications/treatment patient is using for bleeding, including prescribed, over the counter, traditional medicines, and/or herbal supplements[1-11]

Current use	Examples of medications for bleeding	Notes (e.g., dose, suggest to use as prescribed)	Evidence
☐	Platelet transfusion for thrombocytopenia[1-5]		Effective
☐	Mesna oral or IV to prevent cystitis with bleeding[1]		Likely effective
☐	Tranexamic acid (Cyklokapron®)[1,2,5]		Likely effective
☐	Pantoprazole IV (Panto IV®) for GI bleeding[2]		Expert opinion
☐	Octreotide IV (Sandostatin®) for GI bleeding[2]		Expert opinion
☐	➔ Corticosteroids/prednisone[3-11]		Expert opinion
☐	➔ Factor replacement for acquired hemophilia[3]		Expert opinion
☐	➔ 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. ☐	☐	☐	Apply direct **pressure for 10-15 minutes** when the bleeding occurs.[1]
2. ☐	☐	☐	Use **ice packs** to control bleeding of a wound.[1]
3. ☐	☐	☐	Minimize dressing changes when there is bleeding and use saline fluids to soak the dressing before it is removed.[1]
4. ☐	☐	☐	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**

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

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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 breathlessness[1-21]

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

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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
☐	Immediate-release oral or parenteral opioids[1-7,9]		Effective
☐	Non-invasive ventilation (CPAP mask)[1,3-5]		Likely effective
☐	Oxygen for hypoxic patients[2-7,9]		Expert Opinion
☐	Bronchodilators[2,3,6]		Expert Opinion
☐	♥ Diuretics (Edecrin®, Lasix®, Lozide®, Zaroxolyn®)[2,5,8,9,19,20]		Effective
☐	♥ Nitrates (Nitrostat®)[8,9,19,20,25]		Benefits Balanced with Harm
☐	Benzodiazepines if anxiety related - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®)[2,4-7,9,24]		Expert Opinion
☐	➔ 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. ☐	☐	☐	Try a **fan, open window**, or humidifier to increase air flow to your face.[1-7,9]
2. ☐	☐	☐	Try **turning down the temperature** in your house.[2]
3. ☐	☐	☐	Try to rest in **upright positions** that can help you breathe.[2-4,7,9]
4. ☐	☐	☐	Try different **relaxation** and **breathing exercises** (e.g., pursed lip breathing).[2-5,7]
5. ☐	☐	☐	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. ☐	☐	☐	Try **physical activity** (e.g. walking 15-30 min) at least twice a week when breathing stable.[1-4,8,9,19,24,25]
7. ☐	☐	☐	Take **nutrition supplements** if you have difficulty eating.**[1]**
8. ☐	☐	☐	♥ Watch weight gain from retaining fluid by weighing yourself daily at same time.[8,9,20]
9. ☐	☐	☐	♥ Try **limiting your salt intake** to under 1/2 tsp (< 2000mg) per day.[8,9,20]
10. ☐	☐	☐	♥ If you drink >1-2 **alcohol** drinks/day, try to **reduce to 1 drink/day.**[8,9,19,20]
11. ☐	☐	☐	If you smoke, try to stop.[2,8,9,12,13,19,20,25]
12. ☐	☐	☐	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)

☐	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**

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

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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 constipation[1-13]

Question	Mild		Moderate		Severe	
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	☐	4 - 6	☐	7 - 10	☐
Are you worried about your constipation?[2,3]	No/Some	☐	Yes, very	☐		
How many days has it been since you had a bowel movement (compared to normal)?[1-5]	≤ 2 days	☐	≥3 days	☐	≥3 days on meds	☐
How would you describe your stools (colour, hardness, odour, amount, blood, straining)?[1-7]					Blood in stool	☐
Do you have hemorrhoids?[3]	No	☐	Yes	☐		
Do you have any pain in your abdomen?[1-6]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
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	☐			Yes	☐
Does your abdomen feel bloated?[2-4,6] ☐Unsure	No	☐	Yes, some	☐	Yes, a lot	☐
Do you have lots of gas?[2-4,6]	No	☐	Yes	☐		
Does it feel like your rectum is not emptying after a bowel movement, or diarrhea (possible overflow around blocked stool)[2-4,6]	No	☐	Yes	☐		
Have you recently had abdominal surgery?[2,3]	No	☐			Yes	☐
Do you have a fever > 38° C?[3] ☐ Unsure	No	☐			Yes	☐
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	☐	Yes, some	☐	Yes, a lot	☐
Do you have any other symptoms? ☐ Appetite loss,[1-3] ☐ Nausea/vomiting[2,6]	No	☐	Yes, some	☐	Yes, many	☐
➔ Do you have (signs of hypothyroidism):[1-3,5,7-13] ☐ weight gain, ☐ fatigue, ☐ depression, ☐ feeling cold, ☐ deeper voice, ☐ hair loss, ☐ dry skin	No	☐			Yes	☐
➔ Do you have (signs of autonomic neuropathy):[3-5,7,8] ☐ nausea, ☐ urinary problems, ☐ sweating changes	No	☐			Yes	☐
Are you taking medications that cause constipation?[1-6]	No	☐	Yes	☐		
Does your constipation affect your daily activities?[2,3,15]	No[G1]	☐	Yes, some[G2]	☐	Yes, a lot[G≥3]	☐
	1 Mild (Green)		2 Moderate (Yellow)		3 Severe (Red)	
2. Triage patient for symptom management based on highest severity[3]	☐ 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:

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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
☐	Oral sennosides (Senokot®)[1-6,16]		Likely effective
☐	Polyethylene glycol (PEG; RestoraLAX®, Lax-a-day®)[1-6,16]		Likely effective
☐	Bisacodyl (Dulcolax®) and/or lactulose[1-6,16]		Expert Opinion
☐	Suppositories** (Dulcolax®/bisacodyl, glycerin) or Enema[2-6,16]		Expert Opinion
☐	Picosulfate sodium-magnesium oxide-citric acid[2,4,6,16]		Expert Opinion
☐	Methylnaltrexone injection for opioid as cause[1-6]		Effective
☐	Naloxegol for opioid as cause[1,5]		Expert Opinion
☐	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. ☐	☐	☐	Try to use the **toilet 30-60 minutes after meals.**[3,4,6]
2. ☐	☐	☐	**Drink fluids, 6-8** glasses per day, especially warm or hot fluids. Limit your intake of caffeine or alcohol.[1-6]
3. ☐	☐	☐	**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. ☐	☐	☐	Eat **fruit that are laxatives.**[3,4] (pitted dates, prunes, prune nectar, figs)
5. ☐	☐	☐	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. ☐	☐	☐	Have easy access to a **private toilet** or bedside commode. If possible, it is best to avoid a bedpan.[2-6]
7. ☐	☐	☐	If you have a low neutrophil count, **avoid rectal exams, suppositories, enemas.**[2-4,6]
8. ☐	☐	☐	Consider trying **acupuncture.**[16]

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**

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

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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:________________________

Question	Mild	☐	Moderate	☐	Severe	☐
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	☐	4-6	☐	7-10	☐
Have you felt depressed or had a loss of pleasure for 2 weeks or longer?[1-4,6,7]	No	☐	Yes, off/on	☐	Yes, constant	☐
Do you feel down or depressed most of the day?[3,4,6]	No	☐	Yes, off/on	☐	Yes, every day	☐
Have you experienced any of the following for ≥ 2 weeks: ☐ feeling worthless, ☐ sleeping too little or too much, ☐ feeling guilty, ☐ weight gain or weight loss, ☐ unable to think or concentrate?[1-4,7]	No	☐	Yes, some	☐	Yes, a lot	☐
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others?[1-4,6,7]	No	☐			Yes	☐
Does feeling depressed affect your daily activities?[1-4,6,14]	No [G1]	☐	Yes, some [G2]	☐	Yes, a lot [G≥3]	☐
Have you felt tired/fatigued? (ESAS-r fatigue rating)[1-4,7]	No, 1-3	☐	Yes, 4-6	☐	Yes, 7-10	☐
Have you felt agitated (may include twitching or pacing), confused, or slowing down of your thoughts?[1-4]	No	☐	Yes, some	☐	Yes, often	☐
Do any of these apply to you?[1-4,6,7] ☐ Lack of social support, ☐ History of depression, ☐ Substance use/ withdrawal, ☐ Chronic/advanced disease, ☐ Younger age, ☐ Financial problems, ☐ Female, ☐ Dependent children, ☐ Past trauma/abuse, ☐ Cognitive impairment, ☐ Difficulty communicating, ☐ Other health issues unrelated to cancer?	None	☐	Yes, some	☐	Yes, a lot	☐
Do have any concerns that are making you feel more depressed:[2,6] ☐ Life events, ☐ Waiting for test results, ☐ New information about cancer/treatment, ☐ Recently completed treatment, ☐ Spiritual/religious concerns?	No	☐	Yes, some	☐		
Do you have any other symptoms?[1,2,4,6,7] ☐ Fatigue, ☐ Pain, ☐ Sleep changes, ☐ Anxiety	None	☐	Some	☐	Yes, many	☐
➔Do you have (signs of hypothyroidism):[4,7-12] ☐ Weight gain, ☐ Fatigue, ☐ Constipation, ☐ Feeling cold, ☐ Deeper voice, ☐ Hair loss, ☐ Dry skin	No	☐			Yes	☐
	1 Mild (Green)		2 Moderate (Yellow)		3 Severe (Red)	
2. Triage patient for symptom management based on highest severity[1-3,6,7]	☐ Review self-care ☐ Verify medications		☐ Review self-care ☐ Verify medications ☐ Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days		☐ If potential for harm, refer for further evaluation immediately ☐ If no, refer for non-urgent medical attention and alert if on immunotherapy. ☐ Review self-care ☐ 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:

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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
☐	SSRIs - fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), fluvoxamine (Luvox®), escitalopram (Lexapro®)[1-4,7,15]		Effective
☐	SNRIs - venlafaxine (Effexor XR®), duloxetine (Cymbalta®)[1,3,4]		Effective
☐	Tricyclic antidepressants - amitriptyline (Elavil®), imipramine (Tofranil®), desipramine (Norpramin®), nortriptyline (Pamelor®), doxepin (Sinequan®)[1,15]		Effective
☐	Psychostimulants - methylphenidate (Ritalin®)[1-4,7]		Effective
☐	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. ☐	☐	☐	**Physical activity** including yoga.[1,2,6,7,17]
2. ☐	☐	☐	Participate in **support groups** and/or rely on **family/friends** for support.[1-4,6,7]
6. ☐	☐	☐	**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. ☐	☐	☐	**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. ☐	☐	☐	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**

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 diarrhea[1-18]

Have you been tested for c-difficile?[1-5,7-17] ☐Yes ☐No ☐Unsure Results______________________________

Question						
Tell me what number from 0 to 10 best describes your diarrhea (0 = "no diarrhea"; 10 = "worst possible diarrhea")[19]	1-3	☐	4-6	☐	7-10	☐
Are you worried about your diarrhea?[2,3]	No/Some	☐	Yes, very	☐		
How many extra bowel movements are you having per day above normal for you?[1-3,5,7,15,20]	< 4[G1]	☐	4-6[G2]	☐	≥ 7[≥G3]	☐
Do you wake in the night to have bowel movements?[2,7]	No	☐	Yes	☐		
Ostomy: increase in output above normal?[2,7,15,20]	Small	☐	Moderate	☐	Large	☐
➔ Bowel movements/day above normal?[6,8-14,16,17,20]			< 4[G1]	☐	≥ 4[≥G2]	☐
➔ Ostomy: increase in output above normal?[10,13,16,17]			Small	☐	≥ Moderate	☐
➔ Diarrhea overnight or new incontinence?[8,9,11,14,16]	No	☐			Yes	☐
How would you describe your stools (colour, hardness, odour, amount, oily, blood, mucus, straining)?[1-3,5,7]					Blood in stool	☐
➔ Blood or mucus in stool?[6,8-14,16]	No	☐			Yes	☐
Do you have a fever > 38º C?[1-3,5,7-12,14-17] ☐Unsure	No	☐			Yes	☐
Do you have pain in your abdomen or rectum with or without cramping or bloating?[1-3,5,7,15,18]	No	☐	Yes, some	☐	Yes, a lot	☐
➔ Pain in or cramping in your abdomen?[6,8-12,14,16,17]	No	☐			Yes	☐
How much fluid are you drinking per day?[2,3,5]	6-8 glasses	☐	1-5 glasses	☐	Sips	☐
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	☐	Yes, some	☐	Yes, a lot	☐
Does your diarrhea affect your daily activities?[2,3,7,8,10,11,14-16]	No	☐	Yes, some	☐	Yes, a lot	☐
Do you have any other symptoms?[1-3,5,7,15,18] ☐ Appetite Loss ☐ Fatigue ☐ Nausea/vomiting ☐ Mouth sores	No	☐	Some	☐	Yes, many	☐
➔ 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	☐			Yes	☐
Are you on medicines that increase risk of diarrhea (e.g., laxatives)?[2,3,5,10,15,17]	No	☐	Yes	☐		
Any recent travel or contact with others with diarrhea?[2,4,5,7,15]	No	☐	Yes	☐		
Do you have any rectal or ostomy skin breakdown?[2,3,7]	No	☐	Yes	☐		

	1 Mild (Green)	2 Moderate (Yellow)	3 Severe (Red)
2. Triage patient for symptom management based on highest severity[1-3,5,7-17]	☐ 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:

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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
☐	First line treatment: Loperamide (Imodium®)[1-5,7,15]		Likely effective
☐	Octreotide (Sandostatin®) for severe chemo-induced[1-5,7,15]		Likely effective
☐	Psyllium fibre for radiation-induced (Metamucil®)[1,4]		Likely effective
☐	Probiotics for radiation-induced / for chemo-induced[1,4,5,15,21]		Effective / Likely effective
☐	Atropine-diphenoxylate (Lomotil®)[5,11,15]		Expert opinion
☐	Corticosteroid cream if rectal skin irritated[3]		Expert opinion
☐	➔ Loperamide (Imodium®)[5,6,8-12,14,16,17]		Likely effective
☐	➔ 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. ☐	☐	☐	**Drink fluids, 6-8 glasses** per day.[1-5,7,9-12,15,16]
2. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	**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. ☐	☐	☐	**Eat small frequent meals and snacks.**[1-3,7,15]
6. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	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**

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

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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]

Question						
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	☐	4-6	☐	7-10	☐
Are you worried about your fatigue?[1,12]	No/Some	☐	Yes, very	☐		
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	☐			Yes	☐
How would you describe the pattern of fatigue?[1-5,12]	On and off	☐	Constant < 2wks	☐	Constant ≥ 2wks	☐
Does your fatigue affect your daily activities?[1-5,12,23]	No [G1]	☐	Yes, some [G2]	☐	Yes, a lot [G≥3]	☐
Do you have a fever > 38º C?[1,2,12] ☐Unsure	No	☐			Yes	☐
Do you know the results of your last hemoglobin (Hgb) blood test?[1-4,12] Date: ☐Unsure	<LLN-10.0g/dL	☐	<10.0-8.0 g/dL	☐	<8.0 g/dL	☐
Have you lost or gained weight in the last 4 weeks without trying?[1,2,4,12] Amount: ☐ Unsure	0-2.9%	☐	3-9.9%	☐	≥10%	☐
Do you have any other symptoms?[1-4,12] ☐ Anxiety, ☐ Pain, ☐ Appetite loss, ☐ Depression, ☐ Sleep changes, ☐ Poor food or fluid intake	No	☐	Yes, some	☐	Yes, many	☐
➔ Do you have (signs of endocrine toxicity):[2,4,13-21] ☐ appetite loss, ☐ abdominal pain, ☐ headache, ☐ nausea/ vomiting, ☐ vision changes , ☐ weight gain or loss, ☐ constipation, ☐ dizziness, ☐ mood or behaviour changes, ☐ decreased libido, ☐ confusion, ☐ dry skin, ☐ hair loss, ☐ feeling cold, ☐ puffy face	No	☐			Yes	☐
➔ Do you have (signs of pneumonitis):[13-21] ☐ cough, ☐ wheezing, ☐ breathlessness, ☐ chest pain, ☐ fever, ☐ bluish coloured nail beds	No	☐			Yes	☐
➔ Do you have (signs of cardiovascular toxicity):[13-18,20] ☐ irregular heartbeat (e.g., pounding, fast, skipping beats, fluttering), ☐ chest pain, ☐ breathlessness	No	☐			Yes	☐
➔ Do you have (signs of hepatic toxicity):[13-19] ☐ yellow skin/ eyes, ☐ dark urine, ☐ fever, ☐ nausea, ☐ right side abdominal pain, ☐ appetite loss, ☐ increase in bleeding/bruising	No	☐			Yes	☐
➔ Do you have (signs of myositis):[13-16,19,20] ☐ limb weakness, ☐ difficulty standing up, lifting arms, moving around, ☐ muscle pain	No	☐			Yes	☐
➔ Do you have (signs of hemolytic uremic syndrome):[14] ☐ blood in urine/stool or nose/mouth, ☐ less urine, ☐ new/unexplained bruises, ☐ abdominal pain, ☐ pale skin, ☐ vomiting, ☐ confusion/seizures, ☐ swelling	No	☐			Yes	☐
Do you have conditions that cause fatigue[1-5,12,13] (cardiac, lung, liver, kidney, endocrine, neurologic) or drink excess alcohol?	No	☐	Yes	☐		
Are you taking medicines that increase fatigue?[1-4,12,13,15] (e.g., for pain, depression, nausea/vomiting, allergies)	No	☐	Yes	☐		
	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]	☐ Review self-care		☐ Review self-care. ☐ Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If stable, review self-care strategies ☐ 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:

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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
☐	Ginseng (American or Asian)[2,4,5,24]		Likely effective
☐	Methylphenidate (Ritalin®)[2,4,5]		Expert opinion
☐	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. ☐	☐	☐	Track your **fatigue patterns** in a **diary** to help with planning activities.[2-5,12,13]
2. ☐	☐	☐	**Save energy** for things that are important to you.[1-5,12,13]
3. ☐	☐	☐	**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. ☐	☐	☐	**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. ☐	☐	☐	Try **activities** like reading, games, music, garden, experiences in nature.[4,12,30]
6. ☐	☐	☐	Participate in **support groups** or rely on **family/friends.**[1,2,12]
7. ☐	☐	☐	Activities such as relaxation therapy, deep breathing, guided imagery, **massage** with or without aromatherapy, acupressure or acupuncture.[1-5,11,13,32]
8. ☐	☐	☐	Try the following 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. ☐	☐	☐	Try **cognitive behavioural therapy** or mindfulness-based stress reduction to manage your fatigue.[1-5,7,9,12,13,31]
10. ☐	☐	☐	Try home-based bright white **light therapy.**[1,2]

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)?
☐	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**

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

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Fever with Neutropenia Practice Guide

Fever with neutropenia: An absolute neutrophil count (ANC) < 500 cells/mcl (equivalent to < 0.5 x 10^9/L) OR an ANC < 1000 cells/mcl (< 1.0 x 10^9/L) and a predicted decline to 500 cells/mcl or less over the next 48 hours AND a single oral temperature of ≥38.3º C (101 ºF) or a temperature of ≥38.0º C (100.4 ºF) for ≥1 hour.[1-11]

1. Assess severity of the fever and neutropenia[1-19]

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

	1 Mild (Green)	2 Moderate (Yellow)	3 Severe (Red)
2. Triage patient for symptom management based on highest severity[1-7,9-11,21]	☐ Review self-care ☐ Advise to notify if symptom worsens or new symptoms occur in 12-24 hours	☐ Review self-care. ☐ Advise to notify if symptom worsens or new symptoms occur in 12-24 hours ☐ If ≥38.0º for <1 hour, advise to notify if still ≥38.0 after 1 hour.	☐ 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.

Legend: ➔ Immune Checkpoint Inhibitor therapy; NCI-CTCAE G3=Grade 3

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

Additional Comments:

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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
☐	G(M)-CSF for at-risk patients[1-6,8,10,21]		Effective
☐	Antibiotics to prevent infection for high-risk patients[1-3,5-9,11]		Effective
☐	Antifungals to prevent infection for at-risk patients[1-3,5,8,9,11]		Effective
☐	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. ☐	☐	☐	If temperature not ≥38.0º C, perform regular checks using a thermometer in your mouth and track your temperature in a diary.[2] Avoid rectal temperature measurements.[1]
2. ☐	☐	☐	**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. ☐	☐	☐	Consider **drinking fluids**, 6-8 glasses per day to stay hydrated.[2]
4. ☐	☐	☐	**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. ☐	☐	☐	**Avoid crowds and people who might be sick.**[2,5,9]
6. ☐	☐	☐	**Eat** well **cooked foods** and/or **well cleaned uncooked** raw fruits and vegetables.[2]
7. ☐	☐	☐	**Brush your teeth with a soft toothbrush** at least twice a day.[2] Floss daily if it is your normal routine and tolerated.
8. ☐	☐	☐	Take **daily showers** or baths if able (otherwise sponge bath daily).[2]
9. ☐	☐	☐	**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**

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

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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]

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

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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
☐	Saliva substitutes (Biotene®, Moi-Stir®)[1-4,6,7]		Expert opinion
☐	Pilocarpine (Salagen®) saliva stimulant[2-4,7,9,11]		Expert opinion
☐	Anetholtrithion (Sialor®) salivary stimulant[1]		Expert opinion
☐	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**?[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. ☐	☐	☐	**Drink 6-8 glasses** of clear fluids per day.[1,2,4,7,14]
2. ☐	☐	☐	**Avoid foods and drinks that are highly acidic, caffeinated, sugary, salty, spicy**, or very **hot** (temperature).[1-4,7]
3. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	**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. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	**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. ☐	☐	☐	**Avoid tobacco and alcohol**, including alcohol-based mouthwashes.[1-4,14]
10. ☐	☐	☐	Use **moisturizers** or lip balm to protect your lips.[1-4,14]
11. ☐	☐	☐	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. ☐	☐	☐	Use a **cool humidifier** or bedside vaporizer to help reduce the dryness.[1,3]
13. ☐	☐	☐	Consider trying **acupuncture** therapy.[1,4,5]

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**

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]

Question	Mild		Moderate		Severe	
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	☐	4-6	☐	7-10	☐
Are you worried about your mouth sores?[2,10,11]	No/Some	☐	Yes, very	☐		
How many sores/ulcers/blisters do you have?[1-3,5,10,11]	0-4	☐	>4	☐	Coalescing/ Merging/Joining	☐
Do the sores in your mouth bleed?[1,2,10,11]	No	☐	Yes, with eating or oral hygiene	☐	Yes, spontaneously	☐
Are the sores painful?[1-5,10,11,19]	No/Mild[G1] 0-3	☐	Moderate[G2] 4-6	☐	Severe[G≥3] 7-10	☐
Do you see any redness or white patchy areas in your mouth?[2,3,10,11]	No	☐	Yes, some	☐	Yes, a lot	☐
➔ Do you have (signs of skin toxicity):[12-17] ☐ sores/ulcers/blisters in your mouth, ☐ redness or white patchy areas in your mouth, ☐ irritated gums and/or throat?	No	☐			Yes	☐
Do you have a fever > 38º C?[2,10,11] ☐Unsure	No	☐			Yes	☐
Do you have a dry mouth?[2,3,10,11]	No	☐	Yes	☐		
Are you able to eat?[1-4,10,11]	Yes	☐	Yes, soft food	☐	No	☐
➔ Are you able to eat?[12]	Yes, all foods	☐	Yes, most foods	☐	No or soft foods only	☐
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	☐	Yes, some	☐	Yes, a lot	☐
How much fluid are you drinking per day?[2,3,10,11]	6-8 glasses	☐	1-5 glasses		Sips/Unable to swallow	☐
Have you lost weight in the last 1-2 weeks without trying?[1,2,10,11] Amount: ☐Unsure	0-2.9%	☐	3-9.9%	☐	≥10%	☐
Are you having trouble breathing?[2]	No	☐	Yes, some	☐	Yes, a lot	☐
Does your mouth sore(s) affect your daily activities?[1,2,10,11]	No	☐	Yes, some	☐	Yes, a lot	☐
	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:

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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
☐	Benzydamine hydrogen chloride (Tantum® mouth rinse)[1-4,10,11]		Likely effective
☐	Dexamethasone mouthwash[1,10,11]		Likely effective
☐	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
☐	0.5% Doxepin mouth rinse for pain[10,11]		Expert opinion
☐	Mucosal coating agents for pain (Gelclair®)[2,3,5,11]		Expert opinion
☐	Saliva substitutes (Biotene®, Moi-Stir®, Caphosol®)[2,3,10,11]		Expert opinion
☐	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. ☐	☐	☐	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. ☐	☐	☐	**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. ☐	☐	☐	**Rinse your toothbrush** in hot water before using and allow to air dry.[2,3,10,11]
4. ☐	☐	☐	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. ☐	☐	☐	Use **moisturizers** or lip balm to protect your lips.[2,3,10,11]
6. ☐	☐	☐	Use lactobacillus lozenges[1] or xylitol containing lozenges, gum, or popsicles.[10,11]
7. ☐	☐	☐	**Avoid tobacco and alcohol**, including alcohol-based mouthwashes. [2-4,10,11]
8. ☐	☐	☐	D**rink 6-8 glasses** of fluids per day.[2,3,10,11]
9. ☐	☐	☐	**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. ☐	☐	☐	If on **pain medicine**, try taking it **before brushing teeth and eating.**[2,10,11]
11. ☐	☐	☐	**Avoid foods/drinks that are acidic, salty, spicy**, or very hot.[2,4,5,10,11]
12. ☐	☐	☐	During chemotherapy, take ice water or **ice chips** for 30 min.[1-7,9,10,20-22]
13. ☐	☐	☐	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**

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

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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/vomiting[1-17]

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

	1 Mild (Green)	2 Moderate (Yellow)	3 Severe (Red)
2. Triage patient for symptom management based on highest severity[1,2,4,5]	☐ 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:

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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
☐	5-HT_3: ondansetron (Zofran®), granisetron (Kytril®), dolasetron (Anszemet®)[1-9,20-22]		Effective
☐	Olanzapine (Zyprexa®)[1-4,6-9,20-23]		Effective
☐	Fosaprepitant (Emend® IV), aprepitant (Emend®)[1-3,5-9,20-22]		Effective
☐	Triple drug:[2,3,5-9,20-22] dexamethasone, 5 HT_3 (palonosetron), neurokinin 1 receptor antagonist (netupitant) for high emetic risk		Effective
☐	Cannabis/Cannabinoids[1-4,7-9,22]		Effective
☐	Netupitant/palonosetron (NEPA) (Akynzeo®)[1-3,6-9,20,22]		Effective
☐	Dexamethasone (Decadron®) alone or in combination[1-9,20-22]		Likely effective
☐	Gabapentin (Neurontin®)[7]		Likely effective
☐	Progestins[7]		Likely effective
☐	Anticipatory: Lorazepam (Ativan®), haloperidol (Haldol®)[1-9,20,22]		Expert opinion
☐	Metoclopramide (Maxeran®), prochlorperazine (Stemetil®)[1-6,9,20,22]		Expert opinion
☐	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. ☐	☐	☐	**Drink 6-8** glasses of clear fluids per day.[1,4,9]
2. ☐	☐	☐	**Use relaxation techniques** (e.g. guided imagery, progressive muscle relaxation, hypnosis, music therapy).[1,4,6-9,22]
3. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	**Sit upright or recline** with your head raised for 30-60 minutes after meals.[1,4]
7. ☐	☐	☐	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. ☐	☐	☐	Try **acupressure** (e.g., acupressure bracelet) or **acupuncture.**[1,4,9,22,25]

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**

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

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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]

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

	1 Mild (Green)	2 Moderate (Yellow)	3 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:

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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
☐	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
☐	Step 2: Weak opioid: codeine, tramadol, tapentadol[2,3,5-7,9,11-13,15,17,28-30]		Effective
☐	Step 3: Strong opioid: morphine, oxycodone, fentanyl, hydromorphone[1,2,5-7,9,11-13,15-17,28-31]		Effective
☐	Breakthrough pain: extra dose of immediate-release oral opioids or transmucosal fentanyl[1,2,6,7,9,11-17,29]		Effective
☐	Chronic pain: Transdermal buprenorphine, transdermal fentanyl, systemic anesthetics (e.g., mexiletine)[1,2,5,7,9,12,13,15,17]		Effective
☐	Chronic pain: Cannabis/Cannabinoids[1,2,5,7,11]		Likely effective
☐	Refractory pain: Ketamine[4,6,7,13,30]		Benefits balanced with harm
☐	Neuropathic pain: Antidepressant or anticonvulsant[2,3,5-7,9,11,12,16-18,20,23,24,29,32]		Likely effective
☐	→ Prednisone for immunotherapy-related pain[18-24]		Expert opinion
☐	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. ☐	☐	☐	Track **your pain** level when taking medicine and 1-2 hr. after.[1,2,12,15]
2. ☐	☐	☐	Use **medicines to prevent constipation** if taking opioids.[1,2,6,7,9,11-13,15,17,29]
3. ☐	☐	☐	Try **massage** (+/- aromatherapy), **physio, acupressure, acupuncture**, heat/cold, or transcutaneous electrical nerve stimulation.[1,2,6,8,11,16,33-36]
4. ☐	☐	☐	Try **light physical activity** (walk, swim, cycle, stretch, yoga).[1,2,7,11,12,16,37-39]
5. ☐	☐	☐	Try **activities to help you cope** with pain (e.g. listening to music, meditation, breathing exercises, cognitive behavioural therapy (CBT), biofeedback, activities for distraction, relaxation, mindfulness-based stress reduction, guided imagery, progressive muscle relaxation, hypnosis).[1-3,7,11,12,16,33,40-44]
6. ☐	☐	☐	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)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	Patient agrees to use medication to be consistent with prescribed regimen
☐	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not, 10=very)?
☐	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**

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

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

	1 Mild (Green)	2 Moderate (Yellow)	3 Severe (Red)
2. Triage patient for symptom management based on highest severity[1,3,5-8,11,13-17,20]	☐ Review self-care ☐ Verify medications	☐ Review self-care ☐ Verify 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:

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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
☐	Duloxetine[1-6,8-12,16,20-22]		Likely effective
☐	Gabapentin (Neurontin®) and opioid combination[2,3,6,8]		Likely effective
☐	Corticosteroids - prednisone/methylprednisolone[1,3,6,8,11-17]		Expert opinion
☐	Anti-convulsants gabapentin, pregabalin (Lyrica®)[1,3-6,8,9,11,12,16,23]		Expert opinion
☐	Tricyclic anti-depressants: amitriptyline (Elavil®), nortriptyline (Pamelor®), duloxetine (Cymbalta®), venlafaxine (Effexor®), bupropion (Wellbutrin®, Zyban®)[1,3-6,9,11,23]		Expert opinion
☐	Opioids – fentanyl, morphine (Statex®), hydromorphone (Dilaudid®), codeine, oxycodone (OxyContin®), tapentadol (Nucynta®), methadone (Dolophine®)[1,3,5,9,21]		Expert Opinion
☐	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. ☐	☐	☐	**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. ☐	☐	☐	**Neuropathy in feet:** Wear **footwear that fits** you properly and avoid going barefoot.[1,2,5]
3. ☐	☐	☐	**Neuropathy in hands: Wear gloves** when cooking, using oven, or doing dishes.[1,2]
4. ☐	☐	☐	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. ☐	☐	☐	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. ☐	☐	☐	If any neuropathy, to **avoid burns**: **Lower the temperature** of your hot water heater. Use a thermometer to ensure shower or tub water is <110ºF/43ºC.[1,2]
7. ☐	☐	☐	**Avoid** exposing your fingers and toes to **very cold temperatures.**[1]
8. ☐	☐	☐	Try **dangling your legs before you stand up** to avoid feeling dizzy.[1]
9. ☐	☐	☐	For **constipatio**n, try eat a **high-fiber diet** and drink adequate **fluids.**[1,3]
10. ☐	☐	☐	For urinary issues, try to empty bladder at same time every day, bladder re-training exercises, and drink adequate fluids.[1]
11. ☐	☐	☐	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**

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

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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 rash[1-16]

Tell me about the skin rash (e.g., location, onset, what does it look like):[11,13] ______________________

Question						
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	☐	4-6	☐	7-10	☐
Are you worried about your skin rash?[13]	No/Some	☐	Yes, very	☐		
Is the skin rash on one small part of your body (localized) or does it cover other areas (generalized)?[5-7,11,13,18] Adult Body Part / % of total BSA: Arm 9%; Head 9%; Neck 1%; Leg 18%; Anterior trunk 18%; Posterior trunk 18% (Figure labels: 9%, 1%, Front 18%, Back 18%, 9%, 9%, 18%, 18%)	<10% BSA[G1]	☐	10-30% BSA[G2]	☐	>30% BSA[≥3]	☐
➔Is the skin rash localized or generalized[1-4,8-10,12,15,16]			<10% BSA[G1]	☐	>10% BSA[G≥2]	☐
Do you have any open wounds or blisters?[1,3-8,15,16]	No	☐			Yes	☐
Do you have pain or feel burning at the skin rash area?[1,2,5-7,11,13]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Is the rash itchy?[1-16]	No	☐	Yes	☐		
Does the affected area feel tight or swollen?[1-4,10,11,13]	No	☐	Yes	☐		
Have you ever had a rash like this before?[1-3,9,14-16]	No/controlled with treatment	☐			Yes, did not respond to treatment	☐
Does your skin rash affect your daily activities?[1-9,11-15]	No	☐	Yes, some	☐	Yes, a lot	☐
	1 Mild (Green)		2 Moderate (Yellow)		3 Severe (Red)	
2. Triage patient for symptom management based on highest severity[1-12,14-16]	☐ Review self-care. ☐ Verify medications		☐ Review self-care. ☐ Verify medications ☐ Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 weeks.		☐ 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:

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3. Review medications patient is using for skin rash, including prescribed, over the counter, traditional medicines, and/or herbal supplements[1-16]

Current use	Examples of medications for skin rash	Notes (e.g., dose, suggest to use as prescribed)	Evidence
☐	Topical corticosteroids (hydrocortisone, betamethasone, clobetasol propionate)[1-16]		Expert opinion
☐	Antihistamines or antipruritics (hydroxyzine diphenhydramine, cetirizine, loratidine)[1-5,8-10,12,14,15]		Expert opinion
☐	Oral corticosteroids (prednisone, methylprednisolone)[1-12,14-16]		Expert opinion
☐	Antibiotics for infection, or prophylaxis[4-7,11-13,15]		Likely effective
☐	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 strategies[1-16]

- **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. ☐	☐	☐	**Avoid sun** and protect your skin with sunscreen and clothes.[3-8,12-14]
2. ☐	☐	☐	**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. ☐	☐	☐	Use **moisturizing cream** on your skin (e.g. urea-based) daily.[1,3-6,8-15]
4. ☐	☐	☐	Use oatmeal baths if itchy.[4]
5. ☐	☐	☐	Take **warm showers** using mild **non-scented soap.**[5-7,12,13] Avoid hot water and bathing too long.
6. ☐	☐	☐	Use a **cool compress** for itchy skin.[4]

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:
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 weeks if no improvement, symptom worsens, or new symptoms occur[1]

Name	**Signature**	**Date**

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

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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 radiation[1-12]

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	☐	4-6	☐	7-10	☐
Are you worried about your skin reaction?	No/Some	☐	Yes, very	☐		
Is your skin red?[1-3,5-10]	None	☐	Faint/dull	☐	Tender/bright, necrotic	☐
Is your skin peeling/flaking?[1-3,6-8,14]	No/Dry[G1]	☐	Patchy, moist[G2]	☐	Generalized, moist[G3]	☐
Do you have any swelling around the skin reaction area?[1,3,6,8]	No	☐	Yes, some	☐	Yes, pitting edema	☐
Do you have pain at the skin reaction area?[1-3,5-7,10-12]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you feel itchy at the skin reaction area?[1,3,5,6,10-12,14]	No/Mild [G1]	☐	Yes, often [G2]	☐	Yes, constant [G3]	☐
Do you have any open, draining wounds?[1,3,5,6,8]	No	☐			Yes	☐
Is there any odour from the skin reaction area?[1,3]	No	☐			Yes, strong/foul	☐
Do you have any bleeding?[3,5]	No	☐			Yes, from minor trauma	☐
Do you have a fever > 38° C?[3] ☐Unsure	No	☐			Yes	☐
Have you started a new medication?[3]	No	☐	Yes	☐		
Does your skin reaction affect your daily activities?[2-5,7,9,11,12]	No	☐	Yes, some	☐	Yes, a lot	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity[3,5-7]	☐ 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.	

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:

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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
☐	Low-dose corticosteroid cream[1,3-7,10]		Likely effective
☐	Infection: Silver Sulfadiazine (Flamazine)[1,3,4]		Likely effective
☐	Open areas: Hydrocolloid & hydrogel Dressings[1,3-5]		Expert opinion
☐	Moist desquamation: Silicone Dressings[1,3,4,6,7]		Expert opinion
☐	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. ☐	☐	☐	Take **lukewarm/tepid showers** or **baths** using mild non-perfumed soap, and patting dry (no rubbing).[1,3,8,9]
2. ☐	☐	☐	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. ☐	☐	☐	**Wear loose clothes** (e.g., soft breathable fabric like cotton).[1,3,8,9]
4. ☐	☐	☐	Use **deodorant** on intact skin only.[1,3,5,8] Stop using if skin becomes irritated, blisters, or peels.
5. ☐	☐	☐	Use an **electric razor** instead of a wet razor for shaving.[1,3] Stop **shaving** if area becomes irritated.
6. ☐	☐	☐	**Avoid waxing** or other hair removal creams.[3]
7. ☐	☐	☐	**Avoid talcum powder, baby powder, and cornstarch** especially on treatment areas. These products promote fungus growth and infections.[1,3]
8. ☐	☐	☐	**Shower after swimming** in pools and lakes. Avoid swimming if skin is blistered, peeling or irritated.[1,3,8]
9. ☐	☐	☐	**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. ☐	☐	☐	Use warm or room temperature **normal saline compresses up to 4 times a day** if the reaction area is itchy.[1,3]
11. ☐	☐	☐	**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. ☐	☐	☐	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)

☐	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:
☐	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**

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

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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 changes[1-5]

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	☐	4-6	☐	7-10	☐
Are you worried about your sleep changes?[1,2,4,5]	No/Some	☐	Yes, very	☐		
Do you have difficulty falling asleep?[1,2,4,5]	<3 nights/week	☐	3+ nights/week	☐	Takes ≥30 min every night	☐
Do you have difficulty staying asleep?[1,2,4,5]	<3 nights/week	☐	3+ nights/week	☐	Takes ≥30 min every night to go to sleep again	☐
Do you have early morning waking when not desired?[1,2,4,5]	<3 nights/week	☐	3+ nights/week	☐		
How long have these sleep changes been present? [2,4,5] Describe the sleep pattern change.	Less than 1 month	☐	More than 1 month	☐		
Did the onset of this problem occur with another issue?[1-5] Describe.	No	☐	Yes	☐		
Are you taking any medicines that affect sleep (e.g., opiates, steroids, sedatives, etc.)[2-5]	No	☐	Yes	☐		
Do you have other sleep disorders (e.g., loud snoring, choking/gasping, sleep apnea, restless movement, restless legs)?[1-5]	No	☐			Yes	☐
Do you have other symptoms:[1-5] ☐ fatigue, ☐ pain, ☐ nausea, ☐ anxiety, ☐ depression, ☐ hot flashes, ☐ itchy skin, ☐ breathlessness	None	☐	Some	☐	Yes, many	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **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:

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3. Review medications patient is using for sleep changes, including prescribed, over the counter, traditional medicines, and/or herbal supplements[1-4]

Current use	Examples of Medications for sleep changes*	Notes (e.g., dose, suggest to use as prescribed)	Evidence
☐	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®)[2-4]		Expert opinion
☐	Non-benzodiazepine Hypnotics - Zolpidem (Ambien®)[1-4]		Expert opinion
☐	Tricyclic Antidepressants - Amitriptyline (Elavil®)[2-4]		Expert opinion
☐	Neuroleptics - Chlorpromazine (Thorazine®, Ormazine®)[2,4]		Expert opinion
☐	Herbal supplements (Melatonin, Kava, Valerian)[2-4]		Expert opinion
☐	Melatonin receptor agonists - Ramelteon (Rozerem®)[4]		Expert opinion
☐	Trazadone (Desyrel®)[2-4]		Expert opinion
☐	Antihistamines: Diphenhydramine (Benadryl®), Hydroxyzine (Atarax®)[2,4]		Expert opinion
☐	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. ☐	☐	☐	Track your **sleep patterns** in a **diary.**[1,2,5]
2. ☐	☐	☐	Try to go to sleep and **wake at the same time** each day.[1-5]
3. ☐	☐	☐	Try to get **exposed to light** soon after waking and see if it affects your sleep.[1,2,4,5]
4. ☐	☐	☐	Try to **clear your head early evening** (problem solve, write down plan).[1,2,4,5,7]
5. ☐	☐	☐	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. ☐	☐	☐	**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. ☐	☐	☐	Limit the use of the **bedroom for sleep and/or sex.**[1,2,5]
8. ☐	☐	☐	**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. ☐	☐	☐	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. ☐	☐	☐	**Exercise** regularly.[1-5,7,10]
11. ☐	☐	☐	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. ☐	☐	☐	Try a program like **cognitive-behavioural therapy** or personal counseling that provides more in-depth guidance on managing sleep changes.[1-5,11]
13. ☐	☐	☐	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**

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 (NEW)

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 difficulty[1]

Question						
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	☐	4 - 6	☐	7 - 10	☐
Are you worried about your difficulty swallowing?[1]	No/Some	☐	Yes, very	☐		
How much have you had to eat or drink in the last 24 hours?[1,2]	Close to normal[G1]	☐	About half my normal amount[G2]	☐	Minimal to none[G3]	☐
How long does it take for you to eat an average meal?[1]	< 30 minutes	☐	About 30 minutes	☐	>60 minutes or unable to swallow	☐
Does food stick in your throat when you swallow?[1]	No	☐	Yes, some	☐	Yes, a lot	☐
Does swallowing take a great effort?[1]	No	☐	Yes, some	☐	Yes, a lot	☐
Do you have difficulty swallowing pills?[1]	No	☐	Yes, some	☐	Yes, a lot	☐
Do you cough or choke when you eat?	No	☐	Yes, some	☐	Yes, a lot	☐
Have you lost weight because of swallowing problems?[1]	No	☐	Yes, some	☐	Yes, a lot	☐
Do you cough or choke when you drink liquids?[1]	No	☐	Yes, some	☐	Yes, a lot	☐
Do you gag or drool often?[1]	No	☐	Yes, some	☐	Yes, a lot	☐
Were you recently diagnosed with aspiration pneumonia? (fever, short of breath, feeling unwell, change in mucous amount/colour)?[1]	No	☐		☐	Yes	☐
Do you have any other symptoms?[1] ☐ mouth dryness, ☐ anxiety	No	☐	Yes, some	☐	Yes, many	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity[1]	☐ 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:

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3. Review medications patient is using for swallowing difficulty, including prescribed, over the counter, traditional medicines, and/or herbal supplements[1]

Current use	Examples of medications for swallowing difficulty	Notes (e.g., dose, suggest to use as prescribed)	Evidence
☐	Pain medicines 30-40 minutes before meals[1]		Expert opinion
☐	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 strategies[1]

- **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. ☐	☐	☐	Eat **foods that are easier to swallow** (e.g., cooked extra soft foods, add extra sauces or gravy).[1]
2. ☐	☐	☐	**Avoid dry solid food**, nuts, skins, leafy vegetables.[1]
3. ☐	☐	☐	When **eating and drinking, sit upright** (90 degrees), limit distractions/talking, eat slowly with small bites or slips 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. ☐	☐	☐	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. ☐	☐	☐	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**

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

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