



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

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

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

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## Overview and Practice Guide Development

Management of cancer treatment-related symptoms is an important safety issue given that symptoms can become life-threatening and often occur when patients are at home. Over 50% of cancer nurses in Canada provide remote support (telephone, email).<sup>1,2</sup> Despite that higher quality telephone services require use of symptom practice guides to minimize risk, access to and use is variable.<sup>1,2</sup> With funding from the Canadian Partnership Against Cancer, in 2008 we established a pan-Canadian Steering Committee with representation from eight provinces to develop 13 symptom practice guides.

The practice guides were developed using a systematic process guided by CAN-IMPLEMENT<sup>®</sup>.<sup>3-5</sup>

1. We convened a pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Steering Committee including researchers, an information systems researcher, library scientist, advanced practice nurses, and nurse leaders.
2. We conducted a systematic review for *each symptom* to identify clinical practice guideline(s) published in the previous 5 years. Two identified guidelines (fatigue, anxiety/depression) were developed by pan-Canadian panels using rigorous processes.<sup>6,7</sup> Guidelines are syntheses of the best available evidence and are designed to support decision making in practice and health policy.<sup>8</sup> However, identified clinical practice guidelines were not adequate for remote symptom support.
3. We developed 13 symptom practice guides based on the available clinical practice guidelines (median 3 guidelines per practice guide; range 1 to 7). In total, we identified > 40 practice guidelines and their quality was appraised using the AGREE instrument (range 8% to 87%).<sup>9</sup> Higher rigour scores indicate higher confidence that potential biases in guideline development were addressed, and recommendations are valid (both internally and externally) and feasible for practice.<sup>10</sup> Principles for developing the symptom practice guides included:

- Meeting the criteria on the AGREE rigour sub-scale items (e.g. explicit recommendations, linked to evidence, based on systematic review, reviewed by experts).
- Adding relevant questions from the valid and reliable Edmonton Symptom Assessment System (ESAS); a widely used screening instrument for routinely identifying symptoms in cancer patients seen in Canadian programs.<sup>11,12</sup>
- Enhancing usability for remote symptom support and with the potential to integrate into an electronic health record.
- Using plain language to facilitate communication between nurses using the practice guides and patients/families (Flesch–Kincaid Grade Level 6.4).

Each symptom practice guide has five recommendations for the nurse: a) assess symptom severity; b) triage patient for symptom management based on highest severity; c) review medications being used for the symptom; d) review self-management strategies (presented using motivational interviewing techniques);<sup>13</sup> and e) summarize and document the plan agreed upon with the patient.

4. We tested the practice guide usability with cancer nurses and revealed that they: are easy to read; provide just the right amount of information; use appropriate terms; are likely to fit with clinical work flow; and have excellent self-management strategies.
5. We circulated the 13 practice guides for review by cancer experts across Canada. They validated the content of the practice guides and identified the need for local adaptation to integrate the practice guides with their current approaches for handling remote symptom assessments.
6. In March 2013, practice guides were updated with evidence from a systematic review to identify guidelines published up until the end of December 2012. We circulated the 13 updated practice guides for review by the COSTaRS committee members.
7. In 2013-2015 a CIHR funded study was conducted to evaluate the implementation of the symptom practice guides in three different oncology programs in Ontario, Quebec, and Atlantic Canada.
8. In January 2016, with funding from the Canadian Cancer Society (#703679), the 13 symptom practice guides were updated with evidence from a systematic review to identify guidelines published up to August 2015. As well, new practice guides for pain and sleep problems were added. AGREE Rigour Scores for source guidelines were removed given inconsistent reporting. Evidence ratings were changed to indicate how well the medications work (e.g. effective, likely effective, or expert opinion). The 15 practice guides

were reviewed by the current COSTaRS committee members and a summary of changes for the 2016 update are available at <https://decisionaid.ohri.ca/costars/>.

In summary, we have developed 15 user-friendly remote symptom practice guides based on a synthesis of the best available evidence, validated the practice guides with oncology nurses, and used plain language to facilitate use with patients. Now they are available to be used in routine remote support practices.

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- (13) Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change (2nd ed.)*. New York: Guilford Press; 2002.

# 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; worry; apprehension.<sup>3</sup>

Name  
Date of Birth  
Sex  
  
Date and Time




## 1. Assess severity of the anxiety (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Tell me what number from 0 to 10 best describes how anxious you are feeling

Not anxious    0    1    2    3    4    5    6    7    8    9    10    Worst possible anxiety<sup>1(ESAS)</sup>

Do have any concerns that are making you feel more anxious (e.g. life events, new information about cancer/treatment, financial problems)? ☐ Yes ☐ No If Yes, describe: \_\_\_\_\_

### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>1-3</sup>	1 – 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 – 10	<input type="checkbox"/>
Are you having panic attacks; periods/spells of sudden fear, discomfort, intense worry, uneasiness? <sup>2,3</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
How much does your anxiety affect your daily activities at home and/or at work? <sup>2,3</sup> Describe.	Not at all	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
How much does your anxiety affect your sleep? <sup>2,3</sup>	Not at all	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Do any of these apply to you? <input type="checkbox"/> Female <input type="checkbox"/> Waiting for test results, <input type="checkbox"/> Financial problems, <input type="checkbox"/> History of anxiety or depression, <input type="checkbox"/> Younger age (< 30), <input type="checkbox"/> Withdrawal from alcohol/ substance use, <input type="checkbox"/> Living alone, <input type="checkbox"/> Dependent children <input type="checkbox"/> Recurrent/advanced disease, <input type="checkbox"/> Not exercising, <input type="checkbox"/> Recently completed treatment? <sup>2,3</sup>	No	<input type="checkbox"/>	Some	<input type="checkbox"/>	Several	<input type="checkbox"/>
Are you feeling (symptom-related risk factors for anxiety): <sup>3</sup> <input type="checkbox"/> Fatigue, <input type="checkbox"/> Short of breath, <input type="checkbox"/> Pain, <input type="checkbox"/> Sleep problems, <input type="checkbox"/> Other If yes, see appropriate symptom practice guide.	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Several, with ≥1 symptoms assessed as severe	<input type="checkbox"/>
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others? <sup>2,3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
	 <b>1</b> Mild (Green)		 <b>2</b> Moderate (Yellow)		 <b>3</b> Severe (Red)	

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)<sup>2,3</sup>

<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate. <input type="checkbox"/> Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> If potential for harm, refer for further evaluation immediately. <input type="checkbox"/> If no, refer for non-urgent medical attention. <input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.
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If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**



### 3. Review medications patient is using for anxiety, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Current use	Examples of medications for anxiety*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzodiazepines - lorazepam (Ativan <sup>®</sup> ), diazepam, (Valium <sup>®</sup> ), alprazolam (Xanax <sup>®</sup> ) <sup>2,3</sup>		Expert opinion
<input type="checkbox"/>	SSRIs - fluoxetine (Prozac <sup>®</sup> ), sertraline (Zoloft <sup>®</sup> ), paroxetine (Paxil <sup>®</sup> ), citalopram (Celexa <sup>®</sup> ), fluvoxamine (Luvox <sup>®</sup> ), escitalopram (Lexapro <sup>®</sup> ) <sup>2,3</sup>		Expert opinion

\*Use of medications should be based on severity of anxiety and potential for interaction with other medications.<sup>2</sup>

### 4. Review self-care strategies (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing when you feel anxious?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel anxious? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your cancer or your treatment help to ease your worries? If yes, provide appropriate information or suggest resources. <sup>2,3</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help to ease your worries? If yes, provide appropriate information or suggest resources. <sup>2,3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you shared your concerns and worries with your health provider? <sup>3</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What are you doing for physical activity including yoga? <sup>2,3</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in any support groups and/or have family/friends you can rely on for support? <sup>2,3</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation therapy, breathing techniques, listening to music, guided imagery? <sup>2,3</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried massage therapy with or without aromatherapy? <sup>3</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive-behavioural therapy, mindfulness-based stress reduction, or received personal counseling that provides more in-depth guidance on managing anxiety and problem solving? <sup>2,3</sup>

### 5. Summarize and document plan agreed upon with caller including ongoing monitoring (check all that apply)

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

Name	Signature	Date
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References: 1. Bruera E, et al. (1991); 2. Howell D, et al. (2015); 3. ONS-PEP Anxiety (2015). (See pages 36-39 for complete references).

# Appetite Loss Practice Guide

Name  
Date of Birth  
Sex  
  
Date and Time

Anorexia: An involuntary loss of appetite<sup>1,3</sup>; being without hunger.

## 1. Assess severity of the appetite loss (Supporting evidence: 2 guidelines)<sup>2,3</sup>




Tell me what number from 0 to 10 best describes your appetite

Best appetite    0    1    2    3    4    5    6    7    8    9    10    Worst possible appetite <sup>4(ESAS)</sup>

How worried are you about your poor appetite?<sup>3</sup>

Not worried    0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>2,4</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about poor appetite (see above) <sup>3</sup>	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How much have you had to eat and drink in past 24 hours (e.g. at each meal)? <sup>3</sup> (compared to your normal food intake)	Some	<input type="checkbox"/>	Minimal	<input type="checkbox"/>	None	<input type="checkbox"/>
Is there anything causing your lack of appetite: <sup>3</sup> <input type="checkbox"/> Recent surgery or treatment <input type="checkbox"/> New medication <input type="checkbox"/> Other symptoms, describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, several	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine? <sup>3</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Does your poor appetite interfere with your daily activities at home and/or at work? <sup>3</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Have you lost weight in the last 4 weeks without trying? <sup>3</sup> Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
	 <b>1 Mild (Green)</b>		 <b>2 Moderate (Yellow)</b>		 <b>3 Severe (Red)</b>	

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)<sup>3</sup>

<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate. <input type="checkbox"/> Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> If severe loss of appetite is stabilized, review self-care strategies <input type="checkbox"/> If severe loss of appetite is new refer for medical attention immediately.
---	--	---

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional comments:**

### 3. Review medications patient is using for appetite loss, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)<sup>1,2</sup>

Current use	Examples of medications for appetite	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	megestrol (Megace®) <sup>1,2</sup>		Effective
<input type="checkbox"/>	Corticosteroids* - dexamethasone (Decadron®), prednisone <sup>1</sup>		Effective

\* Corticosteroids offer short-lived benefit. Long-term use is associated with significant toxicities. Cannabis/Cannabinoids are not recommended.<sup>1</sup>

### 4. Review self-care strategies (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for improving your appetite?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel like you are not hungry? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat 5-6 small meals? <sup>3</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat more when you feel most hungry? <sup>3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat foods that are higher in protein and calories such as cheese, yogurt, eggs, or milk shakes? <sup>3</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you able to obtain groceries and help prepare your meals (access to food, financial resources)? If preparing meals is a problem ask friends family to help or buy convenience foods. <sup>3</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you drinking any higher energy and protein drinks (Ensure, Glucerna, Boost®)? <sup>1,3</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week) <sup>2</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a dietitian? <sup>1-3</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. ONS-PEP Anorexia (2015); 2. Dy SM, et al. (2008); 3. Cancer Care Ontario (2012); 4. Bruera E, et al. (1991). (See pages 36-39 for complete 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, an alteration of clotting factors, a paraneoplastic syndrome, or a combination of these;<sup>1</sup> hemorrhage.

Name  
Date of Birth  
Sex  
  
Date and Time

## 1. Assess severity of the bleeding (Supporting evidence: 1 guideline)<sup>1</sup>

Where are you bleeding from? \_\_\_\_\_ How much blood loss? \_\_\_\_\_

How worried are you about your bleeding?

Not worried    0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Ask patient to indicate which of the following are present or absent

How much are you bleeding? <sup>1</sup>	Minor	<input type="checkbox"/>	Some	<input type="checkbox"/>	Gross	<input type="checkbox"/>
Patient rating of worry about bleeding (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Do you have any bruises? <sup>1</sup>	No	<input type="checkbox"/>	Few	<input type="checkbox"/>	Generalized	<input type="checkbox"/>
Have you had any problems with your blood clotting? <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? <sup>1</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any blood: <input type="checkbox"/> In your stool or is it black? <sup>1</sup> <input type="checkbox"/> In your urine <input type="checkbox"/> In your vomit or does it look like coffee grounds? <sup>1</sup> <input type="checkbox"/> In your phlegm/sputum when you cough <sup>1</sup> <input type="checkbox"/> Other	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Women only: Has there been an increase bleeding with your menstrual periods? <sup>1</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Do you know what your last platelet count was? <sup>1</sup> Date: <input type="checkbox"/> Unsure	≥ 100	<input type="checkbox"/>	20-99	<input type="checkbox"/>	< 20	<input type="checkbox"/>
Are you taking any medicines that increase the risk of bleeding? (e.g., acetylsalicylic acid (Aspirin), warfarin (Coumadin), heparin, dalteparin (Fragmin), tinzaparin (Innohep), enoxaparin (Lovenox), apixaban (Eliquis)	No	<input type="checkbox"/>	Yes, acetylsalicylic acid	<input type="checkbox"/>	Yes, other blood thinners	<input type="checkbox"/>
If warfarin, do you know your last INR blood count <sup>1</sup> Date: <input type="checkbox"/> Unsure						

1

**Mild**  
(Green)

2

**Moderate**  
(Yellow)

3

**Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)<sup>1</sup>

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional comments:**

### 3. Review medications/treatment patient is using for bleeding, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Current use	Examples of medications for bleeding	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Platelet transfusion for thrombocytopenia <sup>1,3</sup>		Effective
<input type="checkbox"/>	Mesna oral or IV to prevent cystitis with bleeding <sup>1,2</sup>		Effective

### 4. Review self-care strategies (Supporting evidence: 1 guideline)<sup>1</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing the bleeding?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to apply direct pressure for 10-15 minutes when the bleeding occurs? <sup>1</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use ice packs? <sup>1</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a dressing, is there bleeding when it is changed? If yes, do you try to minimize how often the dressing is done, and use saline to help remove the dressing so it does not stick to the tissue? <sup>1</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using any special dressings to control bleeding of a wound (e.g. non-stick gauze, medicated dressing, packing)? <sup>1</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. <sup>1</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a pharmacist or doctor about medications you are taking that may affect bleeding?

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. ONS-PEP Prevention of Bleeding (2015); 2. Hensley ML, et al. (2009); 3. Estcourt L, et al. (2012). (See pages 36-39 for complete references).

# Breathlessness/Dyspnea Practice Guide

Breathlessness/Dyspnea: A subjective experience described as breathing discomfort of varying intensities.<sup>1-4</sup> Includes descriptors such as hard to breathe, feeling smothered, tightness in chest, unable to catch breath, panting, gasping.

Name  
Date of Birth  
Sex  
  
Date and Time

## 1. Assess severity of the breathlessness (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Tell me what number from 0 to 10 best describes your shortness of breath?

No shortness of breath    0   1   2   3   4   5   6   7   8   9   10    Worst possible shortness of breath <sup>5(ESAS)</sup>

How worried are you about your shortness of breath?

Not worried                      0   1   2   3   4   5   6   7   8   9   10    Extremely worried

### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>3,5</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about shortness of breath (see above) <sup>2</sup>	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
With what level of activity do you experience this shortness of breath?	Moderate activity	<input type="checkbox"/>	Mild activity	<input type="checkbox"/>	At rest	<input type="checkbox"/>
Do you pause while talking every 5-15 seconds? <sup>3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have pain in your chest when you breathe? <sup>3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is your breathing noisy, rattily or congested? <sup>3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Did you wake suddenly with shortness of breath? <sup>3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? <sup>3</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes, with breathlessness	<input type="checkbox"/>
Does your shortness of breath interfere with your daily activities at home and/or at work? Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>



**Mild**  
(Green)



**Moderate**  
(Yellow)



**Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)<sup>3</sup>

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional comments:**

### 3. Review medications patient is using for shortness of breath, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Current use	Examples of medications for shortness of breath*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Oxygen <sup>1,2</sup>		Expert Opinion
<input type="checkbox"/>	Immediate-release oral or parenteral opioids - morphine (Statex <sup>®</sup> ), hydromorphone (Dilaudid <sup>®</sup> ), fentanyl <sup>1,2,3</sup>		Effective

\* Palliative oxygen is not recommended.<sup>1</sup>

### 4. Review self-care strategies (Supporting evidence: 3 guidelines)<sup>1,3,4</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing when you feel short of breath?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you are short of breath? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried to use a fan or open window to increase air circulation directed at your face? <sup>1</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried to turn down the temperature in your house? <sup>1,3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to rest in upright positions that can help you breath? <sup>1,3</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying different relaxation and breathing exercises (e.g. diaphragmatic breathing, pursed lip breathing)? <sup>1,3,4</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a wheelchair, portable oxygen or walking aids, are you trying to use them to help with activities that cause your shortness of breath? <sup>1,4</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have difficulty eating, are you taking nutrition supplements <sup>1</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. <sup>1,3</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive behavioural therapy (relaxation therapy, guided imagery) to help manage your shortness of breath? <sup>1,3</sup> (Can decrease anticipatory worry associated with exertional dyspnea)

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. ONS-PEP Dyspnea (2014); 2. Dy SM, et al. (2008); 3. Cancer Care Ontario (2010); 4. Bausewein C, et al. (2008); 5. Bruera E, et al. (1991). (See pages 36-39 for complete references).

# Constipation Practice Guide

Name  
Date of Birth  
Sex  
Date and Time

Constipation: A decrease in the passage of formed stool characterized by stools that are hard and difficult to pass.<sup>1,2</sup>

## 1. Assess severity of the constipation (Supporting evidence: 2 guidelines)<sup>1,2</sup>

Tell me what number from 0 to 10 best describes your constipation

No constipation    0    1    2    3    4    5    6    7    8    9    10    Worst possible constipation<sup>3(ESAS)</sup>

How worried are you about your constipation?<sup>2</sup>

Not worried    0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>3</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about constipation (see above) <sup>2</sup>	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How many days has it been since you had a bowel movement (compared to your normal pattern)? <sup>1,2</sup>	≤ 2 days	<input type="checkbox"/>	3 days or more	<input type="checkbox"/>	3 days or more on meds	<input type="checkbox"/>
How would you describe your stools (colour, hardness, odour, amount, blood, straining)? <sup>2</sup>					Bleeding (gross)	<input type="checkbox"/>
Do you have any pain in your abdomen? <sup>2</sup> Describe.	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Does your abdomen feel bloated? <sup>2,4</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have lots of gas? <sup>2,4</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you feel like your rectum is not emptying after a bowel movement or do you have hemorrhoids? <sup>2,4</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking any medications that cause constipation? <sup>2</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Have you recently had abdominal surgery? <sup>1</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any other symptoms? <input type="checkbox"/> Nausea/vomiting <sup>1,2</sup> <input type="checkbox"/> Loss of appetite <sup>1,2</sup> <input type="checkbox"/> Urinary symptoms such as leaking urine, or feeling like you cannot empty your bladder <sup>2</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Does your constipation interfere with your daily activities at home and/or at work? <sup>2,4</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>



**Mild**  
(Green)



**Moderate**  
(Yellow)



**Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: expert opinion)

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional comments:**



### 3. Review medications patient is using for constipation, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)<sup>1,2</sup>

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

\*Opioid-induced constipation must be considered. Fentanyl and oxycodone+naloxone have less constipation<sup>1</sup>. \*\* Verify blood count before using suppositories.

### 4. Review self-care strategies (Supporting evidence: 2 guidelines)<sup>1,2</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your constipation?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you are constipated? Reinforce as appropriate. <sup>2</sup> Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is your normal bowel routine? Reinforce as appropriate. <sup>1,2</sup> Specify:
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink fluids, 6-8 glasses per day, especially warm or hot fluids? <sup>1,2</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you increased the fiber in your diet to 25g/day?(Only appropriate if adequate fluid intake (1500ml/24 hrs.) and physical activity) <sup>1,2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you eat fruit that are laxatives? (pitted dates, prune nectar, figs, pitted prunes) <sup>2</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week) <sup>2</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have easy access to a private toilet or bedside commode, <sup>1,2</sup> with necessary assistive devices (raised toilet seat)? If possible, it is best to avoid a bedpan. <sup>1</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding non-sterilized corn syrup and castor oil? <sup>1</sup> (Corn syrup can be a source of infection; castor oil can cause severe cramping)
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a low neutrophil count are you trying to avoid rectal exams, suppositories, enemas? <sup>1</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a doctor or pharmacist or dietitian about the constipation? <sup>1,2</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. ONS-PEP Constipation (2015); 2. Cancer Care Ontario (2012); 3. Bruera E, et al. (1991); 4. NIH-NCI (2010). (See pages 36-39 for complete references).

# Depression Practice Guide

Name  
Date of Birth  
Sex  
Date and Time

Depression: a range of feelings and emotions from normal sadness to chronic, depressed emotional affect, feelings of despair, irritable mood, hopelessness.<sup>3</sup>

## 1. Assess severity of the depression (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Tell me what number from 0 to 10 best describes how depressed you are feeling

Not depressed    0    1    2    3    4    5    6    7    8    9    10    Worst possible depression<sup>1(ESAS)</sup>

Do you have any concerns that are making you feel more depressed (e.g. life events, new information about cancer/treatment, financial problems) ☐ Yes ☐ No Specify: \_\_\_\_\_

### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>1,3</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Have you felt depressed or had a loss of pleasure for 2 weeks or longer? <sup>2,3</sup>	No	<input type="checkbox"/>	Yes, off/on	<input type="checkbox"/>	Yes, continuous	<input type="checkbox"/>
Have you experienced any of the following for $\geq 2$ weeks: <input type="checkbox"/> feeling worthless, <input type="checkbox"/> sleeping too little or too much, <input type="checkbox"/> feeling guilty, <input type="checkbox"/> weight gain or weight loss <input type="checkbox"/> unable to think or concentrate? <sup>2,3</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, several	<input type="checkbox"/>
Does feeling depressed interfere with your daily activities at home and/or at work? <sup>2</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Have you felt tired or fatigued? <sup>2,3</sup> Describe.	No	<input type="checkbox"/>	Yes, moderate	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Have you felt agitated (which may include twitching or pacing) or slowing down of your thoughts? <sup>2,3</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Do any of these apply to you? <input type="checkbox"/> younger age (< 30), <input type="checkbox"/> female <input type="checkbox"/> bothersome symptoms, <input type="checkbox"/> a lack of social support, <input type="checkbox"/> history of depression <input type="checkbox"/> financial problems, <input type="checkbox"/> withdrawal from alcohol/substance abuse, <input type="checkbox"/> living alone, <input type="checkbox"/> dependent children, <input type="checkbox"/> recurrent/advanced disease <input type="checkbox"/> recently completed treatment, <sup>2</sup>	None	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, several	<input type="checkbox"/>
Are you feeling (symptom-related risk factors for depression): <sup>3</sup> <input type="checkbox"/> Fatigue, <input type="checkbox"/> Pain, <input type="checkbox"/> Sleep problems, <input type="checkbox"/> Other If yes, see appropriate symptom practice guide.	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Several, with $\geq 1$ symptoms assessed as severe	<input type="checkbox"/>
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others? <sup>2,3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>



**1 Mild**  
(Green)



**2 Moderate**  
(Yellow)



**3 Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)<sup>2,3</sup>

<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate. <input type="checkbox"/> Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> If potential for harm, refer for further evaluation immediately. <input type="checkbox"/> If no, refer for non-urgent medical attention. <input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.
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If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for depression, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Current use	Examples of medications for depression*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	SSRIs - fluoxetine (Prozac <sup>®</sup> ), sertraline (Zoloft <sup>®</sup> ), paroxetine (Paxil <sup>®</sup> ), citalopram (Celexa <sup>®</sup> ), fluvoxamine (Luvox <sup>®</sup> ), escitalopram (Lexapro <sup>®</sup> ) <sup>2,3</sup>		Effective
<input type="checkbox"/>	Tricyclic antidepressants - amitriptyline (Elavil <sup>®</sup> ), imipramine (Tofranil <sup>®</sup> ), desipramine (Norpramin <sup>®</sup> ), nortriptyline (Pamelor <sup>®</sup> ), doxepin (Sinequan <sup>®</sup> ) <sup>3</sup>		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.

### 4. Review self-management strategies (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for feeling less depressed?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel depressed? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your cancer or your treatment help to ease your worries? If yes, provide appropriate information or suggest resources. <sup>2,3</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. <sup>2,3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What are you doing for physical activity? <sup>2,3</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)? <sup>2</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in any support groups and/or have family/friends you can rely on for support? <sup>2,3</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation therapy or guided imagery? <sup>2,3</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive-behavioural therapy, mindfulness-based stress reduction or received personal or couple counseling that provides more in-depth guidance on managing depression? <sup>2,3</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Bruera E, et al. (1991); 2. Howell D, et al. (2015); 3. ONS-PEP Depression (2015). (See pages 36-39 for complete references).

# Diarrhea Practice Guide

Name  
Date of Birth  
Sex  
Date and Time

Diarrhea: An abnormal increase in stool liquidity and frequency over baseline (> 4-6 stools/day) which may be accompanied by abdominal cramping.<sup>4,6,7</sup>

## 1. Assess severity of the diarrhea (Supporting evidence: 7 guidelines)<sup>1-7</sup>

Tell me what number from 0 to 10 best describes your diarrhea

No diarrhea 0 1 2 3 4 5 6 7 8 9 10 Worst possible diarrhea<sup>9(ESAS)</sup>

How worried are you about your diarrhea?<sup>7</sup>

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Have you been tested for c-difficile? If yes, do you know the results?

☐ Yes ☐ No ☐ Unsure Results\_\_\_\_\_

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>9</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about diarrhea (see above) <sup>5,7</sup>	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Think about your normal bowel pattern. How many extra bowel movements are you having per day (including at night), above what is normal for you? <sup>1-8</sup>	< 4 stools	<input type="checkbox"/>	4-6 stools	<input type="checkbox"/>	≥ 7 stools	<input type="checkbox"/>
How would you describe your stools (colour, hardness, odour, amount, oily, blood, straining)? <sup>3,5,6,7</sup>					Bleeding (gross)	<input type="checkbox"/>
Ostomy: How much extra output are you having, above what is normal for you? <sup>3-6,8</sup> <input type="checkbox"/> N/A	Mild increase	<input type="checkbox"/>	Moderate increase	<input type="checkbox"/>	Severe increase	<input type="checkbox"/>
Do you have a fever > 38° C? <sup>3-7</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes, with diarrhea	<input type="checkbox"/>
Do you have pain in your abdomen or rectum with or without cramping or bloating? <sup>3,5-7</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine? <sup>3-7</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Have you been able to drink fluids? <sup>5,6</sup>	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
Does your diarrhea interfere with your daily activities at home and/or at work? <sup>3,6-8</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Do you have any other symptoms? <input type="checkbox"/> Nausea/vomiting <sup>3,4,6,7</sup> <input type="checkbox"/> Loss of appetite <sup>7</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Are you taking any medicines that increase the risk of diarrhea? (e.g., oral sennosides (Senokot®), Docusate sodium (Colace®))?	No	<input type="checkbox"/>	Yes			



**1 Mild (Green)**



**2 Moderate (Yellow)**



**3 Severe (Red)**

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 7 guidelines)<sup>1-7</sup>

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for diarrhea, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 8 guidelines)<sup>1-6,10,11</sup>

Current use	Examples of medications for diarrhea*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Loperamide (Imodium®) <sup>1-6,10,11</sup>		Likely effective
<input type="checkbox"/>	Octreotide (Sandostatin®) <sup>1-6,10,11</sup>		Likely effective
<input type="checkbox"/>	Psyllium fibre for radiation-induced (Metamucil®) <sup>4,11</sup>		Likely effective
<input type="checkbox"/>	Atropine-diphenoxylate (Lomotil®) <sup>4-6</sup>		Expert opinion

\* Sucralfate is not recommended for radiation-induced diarrhea.<sup>4</sup>

### 4. Review self-care strategies (Supporting evidence: 7 guidelines)<sup>3-7, 10,11</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing diarrhea?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have diarrhea? <sup>9</sup> Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 8-10 glasses clear fluids per day (e.g. water, sports drinks, broth, diluted fruit juice)? <sup>3-7,11</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what kinds of foods you should be trying to eat? Suggest: applesauce, oatmeal, bananas, barley, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned turkey or chicken, mashed potatoes, cooked or canned fruit without skin <sup>3-7</sup> (high in soluble fiber and low in insoluble fiber)
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to replace electrolytes (e.g. potassium and sodium or salt) that your body may be losing with the diarrhea by eating foods such as bananas and potatoes, drinking sports drinks or peach/apricot nectar, or oral rehydration drink (1/2 tsp. salt, 6 tsp. sugar, 4 cups water)? <sup>4,7,11</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat 5-6 small meals? <sup>3,5-7</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what to avoid? Suggest: greasy/fried and spicy foods, alcohol and minimize caffeine (<2-3 servings) (coffee, chocolate) <sup>3-7</sup> large amounts fruit juices or sweetened fruit drinks <sup>3,4,7</sup> raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes <sup>4,6,7</sup> (Insoluble fiber), very hot or very cold, sorbitol in sugar-free candy, lactose-containing products (milk, yoghurt, cheese) <sup>3,4,6,7</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to keep skin around your rectum or ostomy clean to avoid skin breakdown? <sup>5,8,7</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been keeping track of the number of stools you are having and are you aware of other problems you should be watching for with your diarrhea? (e.g. fever, dizziness) <sup>3,6</sup> (review criteria listed above in assessment)
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Were you taking probiotics with lactobacillus to prevent diarrhea? <sup>10</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a doctor or pharmacist about medications you may be taking that can cause or worsen your diarrhea? <sup>9,6</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Major P, et al. (2004); 2. Keefe DM, et al. (2007); 3. Benson AB, III, et al. (2004); 4. ONS-PEP Diarrhea (2015); 5. BC Cancer Agency (2004); 6. Schwartz L, et al. (2014); 7. Cancer Care Ontario (2012); 8. NIH-NCI (2010); 9. Bruera E, et al. (1991); 10. Lalla RV, et al. (2014); 11. Vehreschild MJ, et al. (2013). (See pages 36-39 for complete references).

# Fatigue/Tiredness Practice Guide

Fatigue: a subjective feeling of tiredness or exhaustion prompted by cancer or cancer treatment that is disproportionate to the level of recent exertion, is not relieved by rest and interferes with usual daily activities.<sup>1</sup>

Name  
Date of Birth  
Sex  
Date and Time

## 1. Assess severity of the fatigue/tiredness (Supporting evidence: 2 guidelines)<sup>1,2</sup>

Tell me what number from 0 to 10 best describes how tired you are feeling

Not tired      0    1    2    3    4    5    6    7    8    9    10    Worst possible tiredness<sup>3(ESAS)</sup>

How worried are you about your fatigue/tiredness?

Not worried      0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>1,3</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about fatigue (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Do you have the following: shortness of breath at rest, sudden onset of severe fatigue, excessive need to sit or rest, rapid heart rate, rapid blood loss, or pain in your chest? <sup>1</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How would you describe the pattern of fatigue? <sup>1</sup>	Intermittent	<input type="checkbox"/>	Constant/ Less than two weeks	<input type="checkbox"/>	Constant/ Daily for two weeks	<input type="checkbox"/>
Does your fatigue interfere with your daily activities at home and/or at work? <sup>1</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Are there times when you feel exhausted? Describe.	No	<input type="checkbox"/>	Yes, intermittently	<input type="checkbox"/>	Yes, constantly for two weeks	<input type="checkbox"/>
Do you have any treatment side effects such as low red blood cells, infection, fever? <sup>1</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any other symptoms? Anxiety, appetite loss, poor intake of fluids, feeling depressed, pain, sleep problems <sup>1</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Do you drink alcohol? <sup>1</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have other health conditions that cause fatigue (cardiac, breathing, liver changes, kidney)? <sup>1</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking any medicines that increase fatigue? (e.g., medicine for pain, depression, nausea/vomiting, allergies) <sup>2</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		



**1 Mild**  
(Green)



**2 Moderate**  
(Yellow)



**3 Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)<sup>1,2</sup>

☐ Review self-care.

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

☐ If severe fatigue is stable, review self-care strategies  
☐ If severe fatigue is new, refer for non-urgent medical attention.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for fatigue, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)<sup>1,2</sup>

Current use	Examples of medications for fatigue	Notes	Evidence
<input type="checkbox"/>	Ginseng <sup>1,2</sup>		Likely effective but insufficient for some types of ginseng

\*Use of pharmacological agents for cancer-related fatigue is experimental and not recommended (e.g. psycho-stimulants, sleep medications, low dose corticosteroids) unless for select patients at end of life with severe fatigue.<sup>1</sup>

### 4. Review self-care strategies (Supporting evidence: 2 guidelines)<sup>1,2</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your fatigue?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel fatigued/tired? Reinforce as appropriate. <sup>2</sup> Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you understand what cancer-related fatigue is? <sup>2</sup> Provide education about how it differs from normal fatigue, that it is expected with cancer treatment.
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? <sup>2</sup> If yes, provide appropriate information or suggest resources.
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to save energy for things that are important to you? <sup>1,2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What are you doing for physical activity including yoga? <sup>1,2</sup> Moderate level of physical activity during and after cancer treatment is encouraged (e.g. 30 min of moderate intensity activity most days of the week: fast walk, cycle, swim, resistance exercise) *Use with caution in patients with some conditions (i.e. bone metastases)
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you think you are eating/drinking enough to meet your body's energy needs? <sup>2</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried activities such as read, games, music, garden, experiences in nature? <sup>2</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in any support groups and/or have family/friends you can rely on for support? <sup>1,2</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried activities to make you more relaxed (e.g. relaxation therapy, deep breathing, guided imagery, or massage therapy)? <sup>2</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you done any of the following to improve the quality of your sleep? <sup>1,2</sup> Avoid long or late afternoon naps; limit time in bed to actual sleep; go to bed when sleepy; use bed for sleep and sexual activity only; have consistent 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
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive behavioural therapy or mindfulness-based stress reduction to manage your fatigue? <sup>1,2</sup>
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If need a tailored plan, have you spoken with or would you like to speak with a health care professional to help guide you in managing your fatigue? <sup>1,2</sup> (rehabilitation specialist)

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Howell D, et al. (2015); 2. ONS-PEP Fatigue (2015); 3. Bruera E, et al. (1991). (See pages 36-39 for complete references).

# Febrile Neutropenia Practice Guide

Febrile neutropenia: A neutrophil count  $< 1000 \text{ cells/mm}^3$  and a single oral temperature of  $\geq 38.3^\circ \text{C}$  ( $101^\circ \text{F}$ ) or a temperature of  $\geq 38.0^\circ \text{C}$  ( $100.4^\circ \text{F}$ ) for  $\geq 1$  hour.<sup>1,2,4,6,7</sup>

Name  
Date of Birth  
Sex  
Date and Time

## 1. Assess severity of the fever and neutropenia (Supporting evidence: 9 guidelines)<sup>1-9</sup>

How worried are you about your fever?

Not worried    0    1    2    3    4    5    6    7    8    9    10    Extremely worried

What is your temperature in the last 24 hours? Current: \_\_\_\_\_ Previous temperatures: \_\_\_\_\_

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

Ask patient to indicate which of the following are present or absent

An oral temperature of  $\geq 38.0^\circ \text{C}$  ( $100.4^\circ \text{F}$ )<sup>1-8</sup>

	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Last known neutrophil count <sup>1-8</sup> _____ Date: _____ <input type="checkbox"/> Unsure	$>1000 \text{ cells/mm}^3$	<input type="checkbox"/>	Fever plus $\leq 500 \text{ cells/mm}^3$ or $1000 \text{ cells/mm}^3$ with expected drop	<input type="checkbox"/>



**Mild**  
(Green)



**Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 9 guidelines)<sup>1-9</sup>

☐ Review self-care.  
☐ Advise to call back if symptom worsens or new symptoms occur in 12 -24 hours<sup>9</sup>

☐ Refer for medical attention immediately. **Febrile neutropenia treatment with antibiotics should be initiated within 1 hour of presentation.**<sup>3,6</sup> **Collection of clinical and laboratory data to locate potential site or cause of infection is critical prior to starting antibiotics.**<sup>1</sup>

Note: For consistency across symptom practice guides a temperature of  $38.0^\circ \text{C}$  is used.

**Additional Comments:**



### 3. Review medications patient is using for preventing febrile neutropenia or decreasing fever, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 1 guideline)<sup>10</sup>

Current use	Examples of medications	Notes	Evidence
<input type="checkbox"/>	G(M)-CSF <sup>10</sup>		Effective
<input type="checkbox"/>	Antibiotics to prevent infection <sup>10</sup>		Mixed recommendations

\*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.

### 4. Review self-care strategies to minimize risk of infection (Supporting evidence: 3 guidelines)<sup>1,3,4</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			If temperature not $\geq 38.0^{\circ}\text{C}$ , are you checking your body temperature with a thermometer? <sup>4</sup>
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you washing your hands frequently? <sup>1,3</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you eating well cooked foods and/or well cleaned uncooked raw fruits and vegetables? <sup>1</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you brushing your teeth with a soft toothbrush at least twice a day (dental flossing can be done if it does not cause bleeding)? <sup>1</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking daily showers or baths? <sup>1</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid enemas, suppositories, tampons and invasive procedures? <sup>1</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you checking your skin for potential sites of infection (e.g. access devices, rectal area) and keeping these areas clean and dry? <sup>1</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid crowds and people who might be sick? <sup>1</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Freifeld AG, et al. (2011); 2. National Comprehensive Cancer Network (2015); 3. Flowers, C. R., et al. (2013); 4. de Naurois J, et al. (2010); 5. NIH-NCI (2010); 6. Tam CS, et al. (2011); 7. Alberta Health Services (2014); 8. National Institute for Health and Clinical Excellence (2012); 9. Mendes AV, et al. (2007); 10. Neumann S, et al. (2013). (See pages 36-39 for complete references).

# Mouth Sores/Stomatitis Practice Guide

Mouth sores/Stomatitis/Oral Mucositis: An inflammatory and potentially ulcerative process of the mucous membranes, resulting 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.<sup>2,5</sup>

Name  
Date of Birth  
Sex  
  
Date and Time

## 1. Assess severity of the mouth sores (Supporting evidence: 5 guidelines)<sup>1-5</sup>




Tell me what number from 0 to 10 best describes your mouth sores?

No mouth sores    0    1    2    3    4    5    6    7    8    9    10    Worst possible mouth sores<sup>6(ESAS)</sup>

How worried are you about your mouth sores?

Not worried    0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>4,6</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about mouth sores (see above) <sup>4</sup>	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How many sores/ulcers/blisters do you have? <sup>1-4</sup>	0-4	<input type="checkbox"/>	>4	<input type="checkbox"/>	Coalescing/ Merging/Joining	<input type="checkbox"/>
Do the sores in your mouth bleed? <sup>2-4</sup>	No	<input type="checkbox"/>	Yes, with eating or oral hygiene	<input type="checkbox"/>	Yes, spontaneously	<input type="checkbox"/>
Are the sores painful? <sup>1-5</sup>	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you see any redness or white patchy areas (isolated or clustered) in your mouth? <sup>1,2,4,5</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Do you have a dry mouth? <sup>4</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you able to eat and drink? <sup>2-5</sup> If no, can you open and close your mouth? <sup>4</sup>	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
Have you lost weight in the last 1-2 weeks without trying? <sup>4</sup> Amount: <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you having trouble breathing? <sup>4</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Does your mouth sore(s) interfere with your daily activities at home and/or at work? <sup>4</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
	 <b>1 Mild (Green)</b>		 <b>2 Moderate (Yellow)</b>		 <b>3 Severe (Red)</b>	

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 4 guidelines)<sup>1,2,4,5</sup>

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for mouth sores, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 5 guidelines)<sup>2,4,5,7,8</sup>

Current use	Examples of medications for mouth sores	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	benzydamine hydrogen chloride (Tantum mouth rinse) <sup>2</sup>		Likely effective
<input type="checkbox"/>	Oral medications for pain <sup>4,5,8</sup>		Expert opinion
<input type="checkbox"/>	0.5% Doxepin mouth rinse <sup>7</sup>		Expert opinion

\* Chlorhexidine mouth rinse and sulcrate are not recommended for treatment.<sup>2</sup>

### 4. Review self-care strategies (Supporting evidence: 6 guidelines)<sup>1,2,4,5,7,8</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your mouth sores?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have mouth sores? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to rinse your mouth 4 times a day with a bland rinse (or more often if mouth sores)? <sup>2,5,7</sup> 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 15 ml (1 tablespoon) in your mouth for at least 30 seconds and spit out. <sup>1,2,4</sup> Prepare daily at room temperature.
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to brush your teeth at least twice a day using a soft toothbrush and flossing daily or as tolerated (use soft foam toothette in salt/soda water if sores)? <sup>1,2,4,5</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you rinse your toothbrush in hot water before using and allow to air dry before storing? <sup>2,4,5</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you wear dentures and your mouth is sensitive, do you try to use your dentures only at mealtimes? <sup>4,5</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using water-based moisturizers to protect your lips? <sup>1,2,4,5</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you sucking on lactobacillus lozenges <sup>2</sup> or zinc lozenges to prevent mouth sores? Xylitol lozenges or chewing on xylitol gum (max. 6 grams per day) for dry mouth? <sup>4</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid tobacco and alcohol, including alcohol-based mouthwashes? <sup>2,4,5</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 8-10 glasses of fluids per day? <sup>4,5</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat a soft diet? Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes <sup>2,5</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid foods and drinks that are acidic, salty, spicy, or very hot or very cold (temperature)? <sup>2,5</sup>
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During chemotherapy, are you taking ice water, ice chips or ice lollipops for 30 minutes? <sup>2,7</sup>
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For mouth sores, have you considered referral for low level laser therapy? <sup>2,7,8</sup>
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Keefe DM, et al. (2007); 2. ONS-PEP Mucositis (2014); 3. Quinn B, et al. (2008); 4. Cancer Care Ontario (2012); 5. Broadfield L, et al. (2006); 6. Bruera E, et al. (1991); 7. Lalla RV, et al. (2014); 8. Clarkson JE, et al. (2010). (See pages 36-39 for complete references).

# Nausea & Vomiting Practice Guide

Nausea: A subjective perception that emesis may occur. Feeling of queasiness.  
Vomiting: A forceful expulsion of stomach contents through the mouth and may include retching (gastric and esophageal movement without vomiting – dry heaves.)<sup>6,10</sup>

Name  
Date of Birth  
Sex  
  
Date and Time

## 1. Assess severity of nausea/vomiting (Supporting evidence: 4 guidelines)<sup>1,6,7,10</sup>

Tell me what number from 0 to 10 best describes your nausea

No nausea    0    1    2    3    4    5    6    7    8    9    10    Worst possible nausea <sup>8(ESAS)</sup>




Tell me what number from 0 to 10 best describes your vomiting?

No vomiting    0    1    2    3    4    5    6    7    8    9    10    Worst possible vomiting <sup>8(ESAS)</sup>

How worried are you about your nausea/vomiting?

Not worried    0    1    2    3    4    5    6    7    8    9    10    Extremely worried

### Ask patient to indicate which of the following are present or absent

Patient rating for nausea (see ESAS above) <sup>1,6,8</sup>	1-3	<input type="checkbox"/>	4-10	<input type="checkbox"/>		
Patient rating for vomiting (see ESAS above) <sup>1,6,8</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about nausea/vomiting (see above) <sup>6</sup>	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How many times per day are you vomiting or retching? <sup>1,6,7,10</sup> <input type="checkbox"/> No vomiting	≤1	<input type="checkbox"/>	2-5	<input type="checkbox"/>	≥6	<input type="checkbox"/>
Have you been able to eat within last 24 hours? <sup>6,7,10</sup>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Have you been able to tolerate drinking fluids? <sup>6,7,10</sup>	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine? <sup>6,10</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Do you have any blood in your vomit or does it look like coffee grounds? <sup>6</sup> <input type="checkbox"/> No vomiting	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any abdominal pain or headache? <sup>6</sup>	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Does your nausea/vomiting interfere with your daily activities at home and/or at work? <sup>6</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Do you have any other symptoms? <input type="checkbox"/> Constipation <input type="checkbox"/> Pain	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
	 <b>1 Mild (Green)</b>		 <b>2 Moderate (Yellow)</b>		 <b>3 Severe (Red)</b>	

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)<sup>6,7</sup>

<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate. <input type="checkbox"/> Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately.
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If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for nausea/vomiting, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 8 guidelines)<sup>1-5,9-11</sup>

Current use	Examples of medications for nausea/vomiting	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	5HT <sub>3</sub> : ondansetron (Zofran <sup>®</sup> ), granisetron (Kytril <sup>®</sup> ), dolasetron (Anszemet <sup>®</sup> ) <sup>1-5,9,10</sup>		Effective
<input type="checkbox"/>	dexamethasone (Decadron <sup>®</sup> ) <sup>1,2,3,5,9,10</sup>		Likely effective
<input type="checkbox"/>	fosaprepitant, aprepitant (Emend <sup>®</sup> ) <sup>1-5</sup>		Effective
<input type="checkbox"/>	metoclopramide (Maxeran <sup>®</sup> ) <sup>1-5,9,10</sup> prochlorperazine (Stemetil <sup>®</sup> ) <sup>1,2,5,9,10</sup>		Expert opinion
<input type="checkbox"/>	Triple drug: dexamethasone, 5 HT <sub>3</sub> (palonosetron), neurokinin 1 receptor antagonist (Akynzeo) <sup>2,5,11</sup>		Effective
<input type="checkbox"/>	Cannabis (Nabilone, medical marijuana), dronabinol <sup>2,5</sup>		Effective
<input type="checkbox"/>	Gabapentin <sup>5</sup>		Likely effective
<input type="checkbox"/>	Other: lorazepam (Ativan <sup>®</sup> ) <sup>1-3,5,9,10</sup> , haloperidol (Haldol <sup>®</sup> ) <sup>2,5</sup>		Expert opinion

\*Metopimazine is not recommended for practice.<sup>5</sup>

### 4. Review self-care strategies (Supporting evidence: 6 guidelines)<sup>2-5,6,10</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your nausea and vomiting?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have nausea/vomiting? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink clear fluids (e.g. water, sports drinks, broth, gingerale, chamomile tea)? <sup>6,10</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation techniques that may include guided imagery, music therapy, progressive muscle relaxation, and/or hypnosis? <sup>2,3,5,6,10</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking anti-emetic medications before meals so they are effective during/after meals? <sup>5,6</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If vomiting, are you limiting food and drink until vomiting stops? After 30-60 minutes without vomiting, sip clear fluids. When clear fluids stay down, add dry starchy foods (e.g. crackers, dry toast, dry cereal, pretzels). If starchy food stay down, add protein rich foods (e.g. eggs, chicken). <sup>6</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to: - eat 5-6 small meals or snacks? <sup>2,5,6</sup> - eat foods that minimize your nausea and are your "comfort foods"? <sup>2,5</sup> - avoid greasy/fried, highly salty, and spicy foods? <sup>2,5,6</sup> - eat foods that are cold, avoiding extreme temperatures and strong odors? <sup>2,5,6,10</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you sitting upright or reclining with head raised for 30-60 minutes after meals? <sup>6</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing loose clothing? <sup>6</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you rinsing your mouth before eating and keeping your mouth clean (brushing, rinsing)? <sup>6</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried acupuncture or acupressure to help with your nausea/vomiting? <sup>4,5,6</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a dietitian? <sup>10</sup>
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? <sup>5,6</sup> If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Basch E, et al. (2011); 2. NCCN (2015); 3. Gralla RJ, et al. (2013); 4. Naeim A, et al. (2008); 5. ONS-PEP Chemotherapy-Induced Nausea and Vomiting (2015); 6. Cancer Care Ontario (2010); 7. NIH-NCI (2010); 8. Bruera E, et al. (1991); 9. Feyer PC, et al. (2011); 10. Cancer Care Nova Scotia (2004); 11. Hesketh et al. (2015). (See pages 36-39 for complete references).

# Pain Practice Guide

Pain: subjective sensory or emotional discomfort associated with actual or potential tissue damage or described in terms of such damage.<sup>2-5</sup>

Types of pain: a) Somatic pain in skin, muscle and bone described as aching, stabbing, throbbing, and/or pressure;<sup>2,4,6</sup> b) Visceral pain in organs or viscera described as gnawing, cramping, aching, or sharp;<sup>4</sup> c) Neuropathic pain from nerve damage described as burning, tingling, shooting, or pins/needles.<sup>4</sup>

Name  
Date of Birth  
Sex

Date and Time

## 1. Assess the pain and severity (Supporting evidence: 7 guidelines)<sup>2,4-9</sup>

1.1 Tell me about the pain (location, onset, type, duration, radiating)

1.2 Tell me what number from 0 to 10 best describes current pain you have (at worst location)?

No pain      0    1    2    3    4    5    6    7    8    9    10    Worst possible pain <sup>(ESAS)<sup>1</sup></sup>

1.3 How worried are you about your pain?

Not worried      0    1    2    3    4    5    6    7    8    9    10    Extremely worried

### Ask patient to indicate which of the following are present or absent

Patient rating of current pain (see above)	0 – 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Patient rating of worst pain (see above)	0 - 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Patient rating of pain at best	0 - 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Patient rating of worry about pain (see above)	0 - 5	<input type="checkbox"/>	6 – 10	<input type="checkbox"/>		<input type="checkbox"/>
Was the pain onset sudden?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is the pain from a new location?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
How much does pain restrict your daily activities (walking, eating, bathing, sleep)?	None	<input type="checkbox"/>	some	<input type="checkbox"/>	Severe limitations	<input type="checkbox"/>
Does the pain interfere with your mood?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		<input type="checkbox"/>
Are you able to get relief of pain from your medications?	Yes, relief	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	No	<input type="checkbox"/>
How much does the pain medicines restrict your daily activities?	None	<input type="checkbox"/>	some	<input type="checkbox"/>	Severe limitations	<input type="checkbox"/>
Are you feeling other symptoms: constipation, nausea/vomiting, fatigue, itchiness, confusion, new weakness in legs or arms? If yes, see other symptom practice guide(s).	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Several, with ≥1 symptoms assessed as severe	<input type="checkbox"/>

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 5 guidelines)<sup>2,3,4,6,8</sup>



**Mild**  
(Green)

☐ Review self-care.  
☐ Verify medication use, if appropriate.



**Moderate**  
(Yellow)

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.



**Severe**  
(Red)

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides?

**Additional Comments:**

### 3. Review medications patient is using for pain, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 7 guidelines)<sup>2,4,5,6, 8-10</sup>

Current use	Examples of medications for pain*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Step 1: Non-opioid: acetaminophen, NSAIDs, COX-2 inhibitors		Likely effective
<input type="checkbox"/>	Step 2: Weak opioid: codeine, tramadol		Effective
<input type="checkbox"/>	Step 3: Strong opioid: morphine, oxycodone, fentanyl, hydromorphone		Effective
<input type="checkbox"/>	Breakthrough dose		Effective
<input type="checkbox"/>	Antidepressant or anticonvulsant (neuropathic pain)		Likely effective
<input type="checkbox"/>	Prophylactic constipation treatment – sennosides, bisocodyl, lactulose, Polyethylene glycol (PEG), ducosate sodium		Likely effective/ expert opinion

\*Avoid use of long-acting opioids during severe acute pain. If reduced kidney function, fentanyl, methadone, and oxycodone are safest options.<sup>2</sup>

### 4. Review self-care strategies (Supporting evidence: 8 guidelines)<sup>2-9</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for pain relief (e.g., target on scale of 0 to 10)?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a family member or friend helping you manage your pain?
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you understand the plan for taking routine and breakthrough medicines for pain? If no, then educate about pain and pain management
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any concerns or fears about taking pain medicines? If yes, then explore and educate?
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a pain diary to track your level of pain when taking medicine and change in pain about 1-2 hours after taking medicine?
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have pain? Reinforce as appropriate.
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried massage with or without aromatherapy?
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you doing any light exercises (walk, swim, cycle, stretch)?
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you used any physiotherapy or acupuncture?
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using activities to help you cope with the pain such as listening to music, breathing exercises, activities for distraction, relaxation, guided imagery?
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If taking opioids, are you using medicines to prevent constipation?
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have other symptoms, are they under control?

### 5. Summarize and document plan agreed upon with caller including ongoing monitoring (check all that apply)

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

Name	Signature	Date
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References: 1. Bruera E, et al. (1991); 2. Cancer Care Ontario (2010); 3. BC Cancer Agency (2013); 4. Ministry of Health Malaysia (2010); 5. SIGN (2008); 6. National Comprehensive Cancer Network (2015); 7. The British Pain Society (2015); 8. ESMO (2011); 9. Yamaguchi T, et al. (2013); 10. ONS-PEP Pain (2015). (See pages 36-39 for complete references).

# Peripheral Neuropathy Practice Guide

Neuropathy: Described as numbness, tingling, burning, pins and needles, tremor, balance disturbances, pain. 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.<sup>1-3</sup>

Name  
Date of Birth  
Sex  
  
Date and Time

## 1. Assess severity of the neuropathy (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Tell me what number from 0 to 10 best describes your neuropathy/numbness/tingling?

No neuropathy      0    1    2    3    4    5    6    7    8    9    10    Worst possible neuropathy

How worried are you about your neuropathy/numbness/tingling?

Not worried      0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Ask patient to indicate which of the following are present or absent

Patient rating (see above)	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about neuropathy (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Do you have pain in your _____ (neuropathy location)? <sup>1-3</sup> Describe on a scale of 0 to 10.	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you have new weakness in your arms or legs? <sup>1,2</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Have you noticed problems with your balance or how you walk or climb stairs? If yes, how much? <sup>1,2</sup>	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Are you constipated or have difficulty emptying your bladder of urine? <sup>1,2</sup>	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Does your neuropathy/numbness/tingling interfere with your daily activities at home and/or at work (e.g. buttoning clothing, writing, holding coffee cup)? <sup>1,2</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>



**Mild**  
(Green)



**Moderate**  
(Yellow)



**Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)<sup>3</sup>

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.

☐ Refer for medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**



### 3. Review medications patient is using for neuropathy, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 5 guidelines)<sup>1-5</sup>

Current use	Examples of medications for neuropathy*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Duloxetine <sup>1,5</sup>		Likely effective
<input type="checkbox"/>	Anti-convulsants – gabapentin, pregabalin (Lyrica®) <sup>2,4</sup>		Expert opinion
<input type="checkbox"/>	Tricyclic anti-depressants – amitriptyline, nortriptyline, duloxetine (Cymbalta®), venlafaxine (Effexor®), bupropion (Wellbutrin®, Zyban®) <sup>2-4</sup>		Expert opinion
<input type="checkbox"/>	Opioids – fentanyl, morphine (Statex®), hydromorphone (Dilaudid®), codeine, oxycodone <sup>1-3</sup>		Expert Opinion
<input type="checkbox"/>	Topical – lidocaine patch 5% <sup>2,3</sup>		Expert Opinion

\*Note: opioids often combined with anticonvulsants or anti-depressants but increase CNS adverse events requiring careful titration. Carnitine/L-carnitine and human leukemia inhibitory factor are not recommended for practice.<sup>1</sup>

### 4. Review self-care strategies (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal in managing the neuropathy?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps with managing your neuropathy? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you look at your hands and feet every day for sores/blisters that you may not feel? <sup>1,2</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If neuropathy in feet:</b> Do you have footwear that fits you properly? <sup>1,2</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In your home: - are the walkways clear of clutter? <sup>1,2</sup> - do you have a skid-free shower or are you using bath mats in your tub? <sup>1,2</sup> - have you removed throw rugs that may be a tripping hazard? <sup>1,2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When you are walking on uneven ground, do you try to look at the ground to help make up for the loss of sensation in your legs or feet? <sup>1,2</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If any neuropathy:</b> To avoid burns due to decreased sensation: -Have you lowered the water temperature in your hot water heater? <sup>1</sup> -Do you use a bath thermometer to ensure water in shower or tub is < 120°F/49°C? <sup>1</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you try to dangle your legs before you stand up to avoid feeling dizzy? <sup>1,2</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For constipation, do you try eat a high-fiber diet and drink adequate fluids? <sup>1,2</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried acupuncture? <sup>2</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a physiotherapist about: - a walker, cane, or a splint to help with your balance and improve walking? <sup>1,2</sup> - a physical training plan or TENS (transcutaneous electrical nerve stimulation)? <sup>2,3</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with an occupational therapist for suggestions such as: -switching to loafer-style shoes or using Velcro shoe laces -adaptive equipment such as enlarged handles on eating utensils, button hooks, Velcro on computer keys to stimulate sensation?
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller monitoring (check all that apply)

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

Name	Signature	Date
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References: 1. ONS-PEP Peripheral Neuropathy (2015); 2. Stubblefield MD, et al. (2009); 3. NCCN (2015); 4. Caraceni A, et al. (2012); 5. Hershtman D, et al. (2014). (See pages 36-39 for complete references).

# Skin Reaction to Radiation Practice Guide

Name  
Date of Birth  
Sex

Skin reaction/alteration: A change in the colour, texture or integrity of the skin.<sup>3</sup>

Date and Time

## 1. Assess severity of the skin reaction to radiation (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Tell me what number from 0 to 10 best describes your skin reaction




No skin reaction      0    1    2    3    4    5    6    7    8    9    10    Worst possible skin reaction

How worried are you about your skin reaction?

Not worried              0    1    2    3    4    5    6    7    8    9    10    Extremely worried

Site of skin reaction(s) \_\_\_\_\_

### Ask patient to indicate which of the following are present or absent

Patient rating (see above)	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about skin reaction (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Is your skin red? <sup>1-3</sup>	None	<input type="checkbox"/>	Faint/dull	<input type="checkbox"/>	Tender/bright, necrotic	<input type="checkbox"/>
Is your skin peeling? <sup>1-3</sup>	No/Dry	<input type="checkbox"/>	Patchy, moist	<input type="checkbox"/>	Generalized, moist	<input type="checkbox"/>
Do you have any swelling around the skin reaction area? <sup>1,2</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, pitting edema	<input type="checkbox"/>
Do you have pain at the skin reaction area? <sup>2,3</sup>	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you have any open, draining wounds? <sup>2,3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any bleeding <sup>1-3</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, gross	<input type="checkbox"/>
Do you have a fever > 38° C? <sup>2</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes, with skin reaction	<input type="checkbox"/>
Have you started a new medication? <sup>3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your skin reaction interfere with your daily activities at home and/or at work? <sup>2,3</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
	 <b>1 Mild</b> (Green)		 <b>2 Moderate</b> (Yellow)		 <b>3 Severe</b> (Red)	
<b>2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)<sup>1,2</sup></b>	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medication use, if appropriate.		<input type="checkbox"/> Review self-care. Verify medication use, if appropriate. <input type="checkbox"/> Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		<input type="checkbox"/> Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for skin reaction, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)<sup>1-3</sup>

Current use	Examples of medications for skin reaction to radiation therapy	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Prevention: Calendula ointment <sup>1,3</sup>		Likely effective
<input type="checkbox"/>	Mild-moderate: Low-dose corticosteroid cream <sup>1-3*</sup>		Expert opinion
<input type="checkbox"/>	Mild-moderate: Lanolin free hydrophilic cream (i.e.: glaxal base or Lubriderm) <sup>1</sup>		Expert opinion
<input type="checkbox"/>	Open areas: Silver Sulfadiazine (Flamazine) <sup>2-3</sup>		Likely effective
<input type="checkbox"/>	Open areas: Dressing changes <sup>2</sup>		Expert opinion

\*There is insufficient evidence to support or refute other specific topical agents (i.e., corticosteroids, sucralfate cream, ascorbic acid, chamomile cream, almond ointment, polymer adhesive skin sealant) for the prevention of acute skin reaction. Emerging evidence for proteolytic enzymes for treatment of skin reaction from radiation.<sup>4</sup> Biafine<sup>®</sup> and aloe vera are not recommended for radiation skin reaction.<sup>3</sup>

### 4. Review self-management strategies (Supporting evidence: 4 guidelines)<sup>1-4</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your skin reaction?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have a skin reaction? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to take warm showers or immersion in warm baths (not soaking in the tub) using mild non-perfumed soap, and patting dry (no rubbing)? <sup>1-4</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use plain, non-scented, lanolin-free, water-based creams on intact skin only? <sup>1-3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing loose clothes? <sup>2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid using petroleum jelly, alcohol, and perfumed products? <sup>2,3</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using non-metallic deodorant? <sup>2-4</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use an electric razor OR avoid shaving the area that is irritated? <sup>2,3</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding waxing or other hair removal creams? <sup>2</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding skin creams or gels in the treatment area before each treatment? <sup>3</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding wet swim wear in the treatment area? <sup>3</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid temperature extremes in the treatment area (e.g. ice pack or heating pad) to the reaction area? <sup>2,3</sup>
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to protect the treatment area from the sun and the cold? <sup>2,3</sup>
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use normal saline compresses up to 4 times a day? <sup>2</sup>
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid tape or Band-aids in the treatment area? <sup>2,3</sup>
16. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Bolderston A, et al. (2006); 2. BC Cancer Agency (2013); 3. ONS-PEP Radiodermatitis (2015); 4. Chan RJ, et al. (2014). (See pages 36-39 for complete references).

# Sleep Problems Practice Guide

Name  
Date of Birth  
Sex  
Date and Time

Sleep Problems: actual or perceived changes in night sleep resulting in daytime impairment.<sup>3</sup>

## 1. Assess severity of the sleep problem (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Do you have problems with your sleep for 3 or more nights a week?

☐ Yes ☐ No

If yes, tell me what number from 0 to 10 best describes how much your sleep problem affects your daytime activities at home and work?

No problems 0 1 2 3 4 5 6 7 8 9 10 Worst possible problems with daytime activities<sup>1(ESAS)</sup>

How worried are you about your sleep problem?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

### Ask patient to indicate which of the following are present or absent

Patient rating of impact on daytime activities (see ESAS above) <sup>1-3</sup>	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Do you have difficulty falling asleep? <sup>2,3</sup>	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>	≥30 minutes/night	
Do you have difficulty staying asleep? <sup>2,3</sup>	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>	≥30 minutes/night	
Early morning waking when not desired? <sup>2,3</sup>	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>		
How long have these sleep problems been present? <sup>2</sup>	Less than 1 month	<input type="checkbox"/>	More than 1 month	<input type="checkbox"/>		
Did the onset of this problem occur with another issue? <sup>2</sup> Describe.	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking any medicines that affect sleep (e.g. opiates, steroids, sedatives, etc.) <sup>2</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have other sleep disorders (e.g., loud snoring, choking/gasping, sleep apnea, restless movement, restless legs)? <sup>2,3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you feeling (symptom risk factors for sleep problems): fatigue, pain, nausea, anxiety, depression, hot flashes <sup>3</sup> If yes, see other symptom practice guide(s).	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Several, with ≥1 symptoms assessed as severe	<input type="checkbox"/>



**Mild**  
(Green)



**Moderate**  
(Yellow)



**Severe**  
(Red)

## 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)<sup>2</sup>

☐ Review self-care.  
☐ Verify medication use, if appropriate.

☐ Review self-care.  
☐ Verify medication use, if appropriate.  
☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 2-3 days.

☐ Review self-care (If ≥30 minutes see 4.16).  
☐ Verify medication use, if appropriate.  
☐ For other sleep disorders, refer to sleep disorder clinic.

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides? If yes, please specify:

### Additional Comments:

### 3. Review medications patient is using for sleep problems, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Current use	Examples of Medications for sleep problems*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®) <sup>2,3</sup>		Need to balance benefits with harms

\*Use of medications for sleep problems 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.<sup>2,3</sup>

### 4. Review self-care strategies (Supporting evidence: 2 guidelines)<sup>2,3</sup>

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for sleeping (is it realistic e.g. 6 -10 hours sleep/night)? <sup>2</sup>
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have problems sleeping? Reinforce as appropriate.
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you kept a sleep diary?
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wake at the same time each day? <sup>2</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you get exposed to light soon after waking? <sup>2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take time to clear your head early in the evening (problem solve, write down plan)? <sup>2</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a 90 minute buffer zone before intended bedtime (e.g., read, watch TV, crossword puzzle, relax, listen to music, yoga, deep breathing, meditation, guided imagery)? <sup>2</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you go to bed when you are sleepy? <sup>2</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you limit the use of the bedroom for sleep and/or sex? <sup>2</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you can't fall asleep within 20-30 minutes, do you get out of bed and return to bed when you are sleepy? <sup>2</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you restrict napping in the daytime? <sup>2</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If noisy or too much light, do you use ear plugs or eye masks? <sup>2</sup>
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If relevant, do you understand the effect of some medications on sleep? <sup>2</sup> If no, then educate about effect of medications on sleep.
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have other symptoms, are they under control? <sup>3</sup>
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you exercising regularly? <sup>3</sup>
16. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive-behavioural therapy (CBT) or received personal counseling that provides more in-depth guidance on managing sleep problems? <sup>2,3</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

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

Name	Signature	Date
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References: 1. Bruera E, et al. (1991); 2. Howell D, et al. (2012); 3. ONS-PEP Sleep-Wake Disturbances (2015). (See pages 36-39 for complete references).

# Example General Assessment Form

## Practice Guides for the Remote Assessment, Triage, and Management of Symptoms in Adults Undergoing Cancer Treatment

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Sex \_\_\_\_\_

Date and time of encounter \_\_\_\_\_ Caller \_\_\_\_\_  
Type of Cancer \_\_\_\_\_ Primary Oncologist \_\_\_\_\_  
Other practitioners (most responsible) \_\_\_\_\_

### 1. Which symptom(s)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Anxiety                 | <input type="checkbox"/> Constipation      | <input type="checkbox"/> Febrile Neutropenia    | <input type="checkbox"/> Peripheral Neuropathy     |
| <input type="checkbox"/> Appetite Loss           | <input type="checkbox"/> Depression        | <input type="checkbox"/> Mouth sores/Stomatitis | <input type="checkbox"/> Skin Reaction (Radiation) |
| <input type="checkbox"/> Bleeding                | <input type="checkbox"/> Diarrhea          | <input type="checkbox"/> Nausea & Vomiting      | <input type="checkbox"/> Sleep problems            |
| <input type="checkbox"/> Breathlessness/ Dyspnea | <input type="checkbox"/> Fatigue/Tiredness | <input type="checkbox"/> Pain                   | <input type="checkbox"/> Other _____               |

### 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 \_\_\_\_\_

Date of last treatment(s) \_\_\_\_\_

Length of time since symptom started? \_\_\_\_\_

New symptom? ☐ Yes ☐ No ☐ Unsure

Told symptom could occur? ☐ Yes ☐ No ☐ Unsure

Other symptoms? ☐ Yes ☐ No If Yes, specify:

Recent exposure to known virus/flu? ☐ Yes ☐ No ☐ Unsure If Yes, specify \_\_\_\_\_

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

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

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

### 5. See appropriate symptom practice guide(s) for further assessment, triage and management.

## Full list of references

### Anxiety

1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7(2):6-9.
2. Howell D, et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, July 2015.
3. Oncology Nursing Society (ONS). Putting Evidence into practice (PEP): Anxiety. 2015. PEP Topic updated June 19, 2015: <https://www.ons.org/practice-resources/pep/anxiety>

### Appetite Loss

1. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Anorexia. 2015. PEP Topic updated May 11, 2015: <https://www.ons.org/practice-resources/pep/anorexia>
2. Dy SM, et al. Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. *J Clin Oncol* 2008 Aug 10;26(23):3886-95.
3. Cancer Care Ontario. Symptom Management Guide-to-Practice: Loss of Appetite. Toronto, Ontario; 2012.
4. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7(2):6-9.

### Bleeding

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2. Hensley ML, et al. American Society of Clinical Oncology 2008 clinical practice guideline update: use of chemotherapy and radiation therapy protectants. *J Clin Oncol* 2009 Jan 1;27(1):127-45.
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### Constipation

1. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Constipation. 2015. PEP Topic updated July 29, 2015: <https://www.ons.org/practice-resources/pep/constipation>
2. Cancer Care Ontario. Symptom Management Guide-to-Practice: Bowel Care. Toronto, Ontario, Canada; 2012.
3. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7(2):6-9.
4. National Institutes of Health: National Cancer Institute. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.

### Depression

1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7(2):6-9.
2. Howell D, et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, July 2015.
3. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Depression. 2015. PEP Topic updated June 19, 2015: <https://www.ons.org/practice-resources/pep/depression>

### Diarrhea

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2. Keefe DM, et al. Updated clinical practice guidelines for the prevention and treatment of mucositis. *Cancer* 2007 Mar 1;109(5):820-31.
3. Benson AB, III, et al. Recommended guidelines for the treatment of cancer treatment-induced diarrhea. *J*

Clin Oncol 2004 Jul 15;22(14):2918-26.

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5. BC Cancer Agency. BCCA Guidelines for Management of Chemotherapy-Induced Diarrhea. 2004.
6. Schwartz L, et al. Professional Practice Nursing Standards - Symptom Management Guidelines: Cancer-Related Diarrhea. BC Cancer Agency;2014.
7. Cancer Care Ontario. Symptom Management Guide-to-Practice: Bowel Care. Toronto, Ontario, Canada; 2012.
8. National Institutes of Health: National Cancer Institute. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.
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10. Lalla RV, et al. MASCC/ISOO clinical practice guidelines for the management of mucositis secondary to cancer therapy. Cancer 2014 May 15;120(10):1453-61.
11. Vehreschild MJ, et al. Diagnosis and management of gastrointestinal complications in adult cancer patients: evidence-based guidelines of the Infectious Diseases Working Party (AGIHO) of the German Society of Hematology and Oncology (DGHO). Ann Oncol 2013 May;24(5):1189-202.

#### **Fatigue/Tiredness**

1. Howell D, et al. Pan Canadian Practice Guideline for Screening, Assessment, and Management of Cancer-Related Fatigue in Adults Version 2-2015, Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology, April 2015.
2. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Fatigue. 2015. PEP Topic updated May 11, 2015: <https://www.ons.org/practice-resources/pep/fatigue>
3. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

#### **Febrile Neutropenia**

1. Freifeld AG, et al. Clinical practice guideline for the use of antimicrobial agents in neutropenic patients with cancer: 2010 update by the infectious diseases society of america. Clin Infect Dis 2011 Feb 15;52(4):e56-e93.
2. National Comprehensive Cancer Network. Clinical practice guidelines in oncology: Prevention and treatment of cancer-related infections. Version 2. 2015
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6. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7(2):6-9.
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2. National Comprehensive Cancer Network. Clinical practice guidelines in oncology: antiemesis. Version 2. 2015.
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### **Pain**

1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991;7(2):6-9.
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10. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Pain. 2015. PEP Topic updated November 9, 2015: <https://www.ons.org/practice-resources/pep/pain/acute-pain>

### **Peripheral Neuropathy**

1. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Peripheral neuropathy. 2015. PEP Topic updated July 29, 2015: <https://www.ons.org/practice-resources/pep/peripheral-neuropathy>
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3. National Comprehensive Cancer Network. NCCN Clinical practice guidelines in oncology: Adult cancer pain. Version 2. 2015.
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#### **Skin Reaction to Radiation**

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