BC Cancer Agency
CARE + RESEARCH
An agency of the Provincial Health Services Authority

Patient Name:
PHN:

Patient-Reported Information & Symptom Measurement (PRISM)

Please answer the following questions to help us get to know you better. Your answers will help us provide you with the best care possible. This information will become part of your health record and will be available to your health care team. Please feel free to leave any questions blank that you do not wish to answer.

Completed by: Patient ☐ Caregiver ☐ Nurse ☐ Other _____

Date _____

General Information:

1. Marital Status:
   ☐ Single ☐ Married/Common-law/Living with Partner ☐ Divorced/Separated ☐ Widowed
   ☐ Living alone ☐ Living with support person

2. Do you have children living at home? ☐ No ☐ Yes #_____
   Ages: _____

3. Do you have adult dependents living at home? ☐ No ☐ Yes

4. a) To which ethnic or cultural group do you belong? (Check more than one if applicable)
   ☐ Arab/West Asian
   (eg. Armenian, Iranian, Lebanese, Moroccan)
   ☐ Black
   (eg. African, Haitian, Jamaican, Somali)
   ☐ Chinese
   ☐ Filipino
   ☐ Japanese
   ☐ Korean
   ☐ First Nation
   ☐ Metis
   ☐ Inuit
   ☐ Latin-American
   ☐ Caucasian, European
   ☐ South Asian
   (eg. East Indian, Pakistani, Sri Lankan)
   ☐ South-Eastern Asian
   (eg. Indonesian, Laotian, Thai, Vietnamese)
   ☐ Other, Please specify: _____

   b) Which language do you speak? _____

   c) Are there cultural practices that you wish to let us know about? _____
   _____

5. Are you currently employed? ☐ No ☐ Yes

6. Have you currently stopped work due to illness? ☐ No ☐ Yes

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7. What is/was your occupation? _____
   What is your spouse's occupation? _____

8. Do you have additional health coverage? ☐ Don't know ☐ No ☐ Yes

9. Are you receiving Homemaking Services? ☐ No ☐ Yes

10. Are you receiving Home Care Nursing? ☐ No ☐ Yes

Medical Information:

11. Have you ever been told you had a multi-resistant organism, drug resistant organism, MRSA, VRE, CRE, or "Super Bug" ? ☐ Don't know ☐ No ☐ Yes

12. Do you have a family history of cancer? ☐ Don't know ☐ No ☐ Yes

    If you have a family history of cancer, please list who in your family has or had cancer and the type of cancer:

Family Member	Type of Cancer

13. Please indicate if you have or had any of the following (please check all that apply):

☐ Asthma/Emphysema
☐ Arthritis
☐ Stroke
☐ Tuberculosis (TB)
☐ Diabetes
☐ Hepatitis
☐ Joint Replacement
☐ Heart Problems
☐ Blood Clots
☐ Menopause
☐ Depression/mental health concern
☐ High Blood Pressure
☐ Pacemaker
☐ HIV/AIDS
☐ Kidney Disease

☐ Other, please specify _____
☐ Operations, please list _____
_____
_____

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PHN:

14. Do you have any allergies? ☐ Don't know ☐ No ☐ Yes

If you do have allergies, please indicate the type of allergy you have and your reaction to the allergy in the table below:

Allergy	Reaction

(For example: medication, latex, other)

16. Do you have any balance/muscle weakness problems? ☐ No ☐ Yes

17. Have you fallen in the last 6 months? ☐ No ☐ Yes

18. Do you use a cane, walker or wheelchair? ☐ No ☐ Yes

19. Have you used tobacco products in the last 6 months? ☐ No ☐ Yes

20. Are you aware that stopping smoking before cancer treatment and recovery lowers your risk of complications and improves healing? ☐ No ☐ Yes

21. Have you been referred to Quitnow and Health Link BC 811 for provincial smoking cessation services? ☐ No ☐ Yes

22. Have you reduced or quit smoking since you were diagnosed or booked for your cancer treatment? ☐ No ☐ Yes

23. Do you drink beer, wine or other alcoholic beverages? ☐ No ☐ Yes

If yes, how many drinks would you have in a week? _____

24. Please check the number that best describes your level of activity.

0☐ usual activity – no problem

1☐ mild – able to continue normal activity

2☐ change in normal activity – bed rest less than 50% waking hours

3☐ in bed/chair more than 50% waking hours

4☐ bed/chair ridden or unable to care for self

Revised March 2015
Reviewed October 2012

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Wishes or Plans for Health Care

Advance Care Planning is a process by which adults talk over their beliefs, values and wishes for health care with their close family/friend(s) and health care providers in advance of a time when they may not be able to decide for themselves.

1) I know about Advance Care Planning:

Yes ☐ No ☐ Not Sure ☐

2) If yes, do you have wishes and plans for your health care written down?

Yes ☐* No ☐ Not Sure ☐

* If you answered yes, please share a copy with us so that we can understand your wishes and instructions.

3) If you answered no to question 2, would you like to discuss this with someone on the healthcare team?

Yes ☐ No ☐ Not Sure ☐

4) I would like more information about Advance Care Planning

Yes ☐ No ☐ Not Sure ☐

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November 06, 2012

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Symptom Self Assessment

Please check the number that best describes how you feel NOW:

No pain ☐	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible pain ☐
No tiredness ☐ (*Tiredness = lack of energy)*	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible tiredness ☐
No drowsiness ☐ (*Drowsiness = feeling sleepy)*	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible drowsiness ☐
No nausea ☐	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible nausea ☐
No lack of appetite ☐	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible lack of appetite ☐
☐ No shortness of breath	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible shortness of breath ☐
No depression ☐	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible depression ☐
No anxiety ☐ (*Anxiety = feeling nervous)*	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible anxiety ☐
☐ Best feeling of wellbeing (*Wellbeing =how you feel overall)*	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible wellbeing ☐
No _____ other problem (*for example, constipation)*	☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10	Worst possible _____

* Adapted from the **Edmonton Symptom Assessment System (ESAS)** with permission

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PSSCAN-R Psychological Screening

Please answer the following questions to help us learn more about your well being. A serious illness can affect the quality of your life in many ways. We may contact you to offer our counselling services based on the information you provide to us, or contact you regarding opportunities to participate in research.

Part A:
Please respond to each question with "Yes" or "No" by making a check beside the appropriate answer. There are no right or wrong answers.

1. Do you live alone? No ☐ Yes ☐

2. When you need help, can you count on anyone to help with daily tasks such as grocery shopping, cooking, giving you a ride? No ☐ Yes ☐

3. Do you have regular contact with friends or relatives? No ☐ Yes ☐

4. Have you lost your life partner within the last few years? No ☐ Yes ☐

5. Can you count on anyone to provide you with emotional support? No ☐ Yes ☐

Part B:
Please check all of the following items that have been of concern or a problem for you in the past week including today.*

6. **Emotional:** ○ Fears/Worries ○ Sadness ○ Frustration/Anger ○ Changes in appearance ○ Intimacy/Sexuality	7. **Informational:** ○ Understanding my illness/treatment ○ Talking with the health care team ○ Making treatment decisions ○ Knowing about available resources
8. **Practical:** ○ Work/School ○ Finances ○ Getting to & from appointments ○ Accommodation	9. **Spiritual:** ○ Meaning/Purpose of life ○ Faith
10. **Social/Family:** ○ Feeling a burden to others ○ Worry about family/friends ○ Feeling alone	11. **Physical:** ○ Concentration/Memory ○ Sleep ○ Weight

Other concerns, please specify: _____

*** Canadian Problem Checklist** developed by the Canadian Partnership Against Cancer, August 2010.

Patient Name: **PHN:**

Part C: Please place an 'X' in the box that best describes what you have experienced.

	Not at all	A little bit	Moderately	Quite a bit	Very much
12. **During the past week** I have felt my heart race and I tremble.	☐	☐	☐	☐	☐
13. **During the past week** I have felt that I cannot control anything.	☐	☐	☐	☐	☐
14. **During the past week** I have lost interest in things I usually cared for or enjoyed.	☐	☐	☐	☐	☐
15. **During the past week** I have felt nervous and shaky inside.	☐	☐	☐	☐	☐
16. **During the past week** I have felt tense and cannot relax.	☐	☐	☐	☐	☐
17. **During the past week** my thoughts are repetitive and full of scary things.	☐	☐	☐	☐	☐
18. **During the past week** I have felt restless and find it difficult to sit still.	☐	☐	☐	☐	☐
19. **I have *recently*** thought about taking my life. **NOTE: If you have, please speak with a member of your health care team and/or your family doctor today.**	☐	☐	☐	☐	☐
20. **In the past year,** I have had 2 weeks or more during which I felt sad, blue or depressed.	☐	☐	☐	☐	☐
21. **I have had 2 years or more in my life** when I felt depressed or sad most days even if I felt okay sometimes.	☐	☐	☐	☐	☐

Thank you for taking the time to respond to this form.

If you or your family is currently struggling with the stress of your diagnosis, information and support is available on our website: www.bccancer.bc.ca/PPI/copingwithcancer or by calling:

BC Cancer Agency Patient & Family Counselling Departments

Abbotsford Centre	604.851.4733
Sindi Ahluwalia Hawkins Centre for the Southern Interior	250.712.3963
Centre for the North	250.645.7330
Fraser Valley Centre	604.930.4000
Vancouver Centre	604.877.6000 x 672194
Vancouver Island Centre	250.519.5525

Patient and Family Counselling Documentation:

D = _____ A = _____

Comments: _____

Reviewed by: _____

Date: _____

Revised April 2014
Review April 16, 2012

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Nutrition Screening Tool

Today's Date: _____

1. What is your current weight?_____ pounds (or_____ kilograms)

   How tall are you? _____

2. Have you lost weight recently without trying?

   ☐ No **(If NO, please go to question 3)**

   ☐ Yes

   ☐ Unsure

   If YES, how much weight have you lost?

   ☐ 2-13 lbs (1)

   ☐ 14-23 lbs (2)

   ☐ 24-33 lbs (3)

   ☐ More than 33 lbs (4)

   ☐ Unsure (2)

   Over what time period have you lost this weight?

   ☐ Over the past two weeks

   ☐ Over the past month

   ☐ Over the past six months or more

   Are you still losing weight? _____ ☐ No ☐ Yes ☐ Unsure

3. Have you been eating poorly because of a decreased appetite? ☐ No (0) ☐ Yes (1)

   If YES, how much are you eating now?

   ☐ about 75% of my usual amount

   ☐ about 50% of my usual amount

   ☐ about 25% of my usual amount

4. Are you having problems chewing food? ☐ No ☐ Yes

5. Are you having problems swallowing food? ☐ No ☐ Yes

6. Are you having 3 or more watery bowel movements per day? ☐ No ☐ Yes

For Health Professional Use:

Revised April 2014