Cancer Centre of Southeastern Ontario
A Cancer Care Ontario Partner

Kingston Health Sciences Centre | Centre des sciences de la santé de Kingston

Initial Health Assessment (IHA) - Oncology

Section A: Please start to fill out this form before your appointment. The information will help us work together to plan your care. Do not write in the shaded areas; the shaded areas will be completed by staff.

What is your preferred name? _____

How would you like us to get in touch with you? ☐ Telephone ☐ Email If **email**: _____	Obtain KHSC *Patient Consent for Email Contact.*
Your health care team will ask about your medication and supplement history. Please bring medications and supplements to your appointment.	Complete Best Possible Medication History.
Do you have any adverse reactions, allergies, or intolerances? ☐ No ☐ Yes	If Yes, document in electronic Patient Care System.

Do you use any of the following aids? ***(check all that apply)***

Visual	Hearing Aid	Mobility	Breathing
☐ Glasses ☐ Contacts ☐ Eye Prosthesis: ☐ Right ☐ Left	☐ Right ☐ Left ☐ Both ears	☐ Cane ☐ Crutches ☐ Walker ☐ Wheelchair ☐ Electric chair/scooter ☐ Prosthesis	☐ BiPAP (Bilevel Positive Airway Pressure) ☐ CPAP (Continuous Positive Airway Pressure) ☐ Home oxygen _____ L(litres)/min ☐ Ventilator

Other: _____

What do you do for work? _____ Are you a veteran? ☐ No ☐ Yes Do you have any financial concerns if work is stopped? ☐ Not Applicable ☐ No ☐ Yes	If Yes to financial concerns, consider adding Social Work to consult list with patient consent.
Is there anyone at home that depends on you? (Example: partner, child, parent, other.) ☐ No ☐ Yes Do you live alone? ☐ No ☐ Yes Do you have help at home? ☐ No ☐ Yes **If Yes,** what help do you have at home? _____	
Are you planning to have children in the future or think you may want to? ☐ No ☐ Yes	If Yes, provide fertility risk and preservation options.
Social Workers can offer you and your family social, emotional, practical, and mental health support at any point in your cancer journey. Would you like to speak to a Social Worker? ☐ No ☐ Yes	If Yes to any, consider adding Social Work to consult list with patient consent.
Spiritual Care Services help patients and their families to cope with the spiritual and emotional aspects of serious illness. Would you like to speak to Spiritual Care? ☐ No ☐ Yes	If Yes to Spiritual Care, consider adding Spiritual Care consult to list with patient consent.

For Staff Use Only:
Date (yyyy/mm/dd): _____ Time (hhmm): _____ Initials: _____

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We have services available for people who identify as having Indigenous ancestry. Would you like to meet with the Indigenous Navigator to learn more? ☐ No ☐ Yes	If Yes, refer to the Indigenous Navigator, EXT. 3851

Do you use recreational drugs? ☐ No ☐ Yes

If **Yes**, Type of drug? _____

How much? _____ How often? _____

Do you use alcohol? ☐ No ☐ Yes

If **Yes**, How many drinks per day?_____ How many days a week?_____ Number of years? _____

In Indigenous culture, sacred tobacco is used mainly for prayer. Commercial tobacco includes cigarettes, pipes, chewing tobacco, and cigars Have you used commercial tobacco or cigarettes in the past 6 months? ☐ No ☐ Yes If **Yes**, how many cigarettes a day?_____; for how many years?_____	Document "No" or "Yes" in electronic Patient Care System.

What is your usual weight? (kilograms) _____

MALNUTRITION SCREENING TOOL (MST) – *Please answer questions A and B*

A. Have you lost weight recently without trying? **(*check one*)**		**B.** Have you been eating less because of poor appetite? **(*check one*)**	
☐ No	**0**	☐ No	**0**
☐ Unsure	**2**	☐ Yes	**1**
☐ Yes, how much weight have you lost?		Question A Score:	
☐ 2 – 13 pounds (1 – 5 kilograms)	**1**	Question B Score:	
☐ 14 – 23 pounds (6 – 10 kilograms)	**2**	**TOTAL** Score:	
☐ 24 – 33 pounds (11 – 15 kilograms)	**3**	If total score is 2 or more, consult Registered Dietitian with patient consent.	
☐ 34 pounds or more (15 kilograms or more)	**4**	☐ Patient consented to Dietitian consult	
☐ Unsure	**2**	☐ Patient declined Dietitian consult	

Do you use nutrition supplement drinks? ☐ No ☐ Yes
(For example: Ensure, Boost, Glucerna)
If **Yes**, what kind? _____ How many drinks per day? _____

Do you use a blood sugar meter? ☐ No ☐ Yes
If **Yes**, How often?_____ What is your blood sugar normally? (mmol/L) ____
Has your blood sugar changed lately? ☐ No ☐ Yes

When was your last visit to the Dentist? (yyyy/mm/dd) _____
Dentist Name/Office: _____ Telephone: _____
Do you have any dental problems right now? _____
Do you wear dentures? ☐ No ☐ Yes
If **Yes**, ☐ Upper ☐ Lower ☐ Partial

For Staff Use Only:

☐ Initial Health Assessment – Oncology reviewed/completed with patient/family member/other.

Date (yyyy/mm/dd): _____ Time (hhmm): _____ Initials: _____

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Section B: To Be Completed By Staff.

What is your understanding of why you are here today?

Do you have a family history of cancer?

Past / Current Medical History and Recent Hospitalizations:

Date (yyyy/mm/dd): _____	Time (hhmm): _____	Initials: _____

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Section B: To Be Completed By Staff.

INTERPROFESSIONAL PROGRESS NOTES

Date (yyyy/mm/dd)	Time (hhmm)	Provider	Focus	Legend for DARP D – Data A – Analysis/Action R – Response P - Plan NOTES

BEHAV - Behaviour/Affect
BLEED - Bleeding/Hemorrhage
COGN - Cognitive Status/Thought Process
COMM - Communication
CVS - Cardiovascular Status
D/C PLAN - Discharge and/or Follow-up Planning
D/C TRANS - Discharge/Transfer
EDUC - Education (Patient/Family)
EVENT - Significant Event (including critical event, adverse event and near miss)
FLD/LYTES - Fluid Balance/Electrolyte Imbalance
GI - Gastrointestinal Status
GU - Genitourinary Status (including dialysis)
IC - Infection Control/ Isolation
MED - Medication
MSK - Musculoskeletal Status
NEURO - Neurological Status
IV - Peripheral IV/ Vascular Access Central Line Therapy
LAB - POCT/ Lab Results
NUTR/SWAL - Nutrition Intake/Feeding/Swallowing
PROC/DI - Procedures/Diagnostic Tests
PSYCH/SOC - Psychosocial Status
RESP - Respiratory Status
SAFETY - Safety/Risk Reduction
SKIN/WOUND - Skin Integrity/Wound Care
SOC - Family/Social
VS - Vital Signs (including pain)
NRS – Numeric Rating System

Printed Name	Designation	Signature	Initials