HaNC

Getting it right for every patient every time

# Aintree Holistic Needs Assessment

*Diagnosis*

Date

Name

Hospital/NHS Number

Diagnosis Date:

Diagnosis:

Pathway Point:

*Shaded area for office use only*

**Overall level of distress during the last seven days:**

| | | |
|---|---|---|
| 10 | Extreme Distress | ☐ |
| 9 | | ☐ |
| 8 | | ☐ |
| 7 | | ☐ |
| 6 | | ☐ |
| 5 | | ☐ |
| 4 | | ☐ |
| 3 | | ☐ |
| 2 | | ☐ |
| 1 | | ☐ |
| 0 | No Distress | ☐ |

## Cause of Cancer

- ☐ Lifestyle issues (smoking/alcohol)
- ☐ HPV
- ☐ Other

The amount of information patients and their family would like after the time of diagnosis of their cancer varies considerably. This **Patient Concerns Inventory** (diagnosis) is a checklist to help patients and their family **raise issues that they want to talk about** with the doctors, nurses and allied health professionals.

***Tick as many or as few as you wish*** *to help you remember what you want to discuss with our head and neck team.*

## Treatment Related

- ☐ Investigations needed (MRI/CT)
- ☐ Investigation results
- ☐ Cancer treatment: what choices of treatment are available
- ☐ Treatment intent: cure or palliation
- ☐ Clinical trials - contributing to research
- ☐ Nutrition/feeding tube/PEG
- ☐ What are the side effects/toxicity/complications of treatment
- ☐ Surgery: length of stay in hospital, neck dissection, laser, free
- ☐ Radiotherapy: mould room, # of treatments, sore mouth/skin
- ☐ Chemotherapy: number of treatments, deafness, nausea
- ☐ What is the chance of cure
- ☐ When will I know if I am all clear or if the treatment was
- ☐ What treatments are available if the cancer comes back
- ☐ How long am I likely to live
- ☐ Waiting time for commencement of treatment
- ☐ Duration of treatment
- ☐ Dental check up

## What Will I Be Like

- ☐ What are the main issues that patients find important e.g. speech, swallowing
- ☐ What 'quality of life' do patients report

## Relating to the "Follow-up"

- ☐ What sort of follow up do I need? How often? What scans/ tests?
- ☐ Patient and Carer Support Group (meet other patients)

## Social Care & Social Well being

- ☐ Carer
- ☐ Dependants/children
- ☐ Finance / money
- ☐ Benefits / what's free and what's not
- ☐ Time off work
- ☐ Home Care / District Nurse
- ☐ Recreation
- ☐ Relationships
- ☐ Speech / voice / being understood
- ☐ Support for my family

## Emotional/Spiritual Well-being

- ☐ Appearance
- ☐ Angry
- ☐ Anxiety
- ☐ Coping
- ☐ Depression
- ☐ Intimacy
- ☐ Fear of adverse events
- ☐ Memory
- ☐ Mood
- ☐ Self esteem
- ☐ Sexuality
- ☐ Spirituality and religious aspects
- ☐ Personality and temperament

## Physical and Functional Well-being

- ☐ Activity
- ☐ Appetite
- ☐ Coughing
- ☐ Dry mouth
- ☐ Energy levels
- ☐ Hearing
- ☐ Indigestion
- ☐ Mobility
- ☐ Mucous
- ☐ Nausea
- ☐ Regurgitation
- ☐ Salivation
- ☐ Shoulder
- ☐ Sleeping
- ☐ Smell
- ☐ Sore mouth
- ☐ Swallowing
- ☐ Swelling
- ☐ Taste
- ☐ Weight
- ☐ Bowel habit
- ☐ Chewing/eating
- ☐ Vomiting / Sickness
- ☐ Pain elsewhere
- ☐ Dental Health / teeth
- ☐ Fatigue / tiredness
- ☐ Mouth opening
- ☐ Pain in the head and neck

## Multi-Disciplinary Team

*Tick below if you would like to learn more about how these professionals can help to support you.*

- ☐ Dietician
- ☐ Dentist
- ☐ Surgeon
- ☐ General Practitioner
- ☐ Clinical Psychologist
- ☐ Dental Hygienist
- ☐ Nursing Staff
- ☐ Physiotherapist
- ☐ Audiologist
- ☐ Chaplain
- ☐ Financial Advisor
- ☐ Social Worker
- ☐ Occupational Therapist
- ☐ Emotional Support Therapist
- ☐ Speech and Language Therapist
- ☐ Clinical Nurse Specialist
- ☐ Oncologist/Radiotherapist
- ☐ Oral Rehabilitation Team

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# Aintree Holistic Needs Assessment

*Diagnosis*

Patient: _____

NHS/Hospital Number: _____

## Care Plan

*During my holistic needs assessment, these issues were identified and discussed:*

| | Issue | Summary of discussion | Actions required/by (name and date) |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

Other actions/outcomes e.g. additional information given, health promotion, smoking cessation, 'My Actions':

Signed (patient) _____ Date _____

Signed (healthcare professional) _____ Date _____

| Diagnosis Date: | Diagnosis: |
|---|---|
| Pathway Point: | |

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