Oral Chemotherapy Care Assessment

Taking care of yourself can be difficult……

How well are we doing in helping you?

Over the past one month, when I received care, I was:

1. Given a written copy of my list of current medications
   ☐ Yes ☐ No ☐ I don't know

2. Given a written list of things I should do if I experience a side effect/ symptom with my oral cancer medicines
   ☐ Yes ☐ No ☐ I don't know

3. Asked to talk about any problems with my medicines or their effects
   ☐ Yes ☐ No ☐ I don't know

4. Contacted once I started my oral cancer medication to see how things were going
   ☐ Yes ☐ No ☐ I don't know

How well are you doing?

1. The last time you had a symptom how quickly did you recognize it as a side effect of your oral cancer medication?
   ☐ I didn't ☐ It took me a while ☐ Fairly quickly
   ☐ Immediately ☐ I haven't had a symptom

2. The last time you had a symptom from your oral cancer medication did you know what to do?
   ☐ Yes ☐ No ☐ Not applicable

3. How confident are you that you could do something to relieve your symptoms?
   ☐ Not confident ☐ Somewhat confident
   ☐ Very confident ☐ Extremely confident

OPTIONAL:

Date: _____ **Patient #:** _____ **Drug:** _____