Initial Intake Oral Cancer Therapy

Name: _____
MRN: _____
DOB: _____

DIAGNOSIS

Diagnosis: _____ Stage: _____

Goals of therapy: [ ] Curative [ ] Palliative Other: _____

ALLERGIES

Allergies: _____

ORAL CANCER THERAPY

Order date: _____ Start date: _____

Generic/Brand names: _____ _____

Dose _____mg Frequency_____ Prescription quantity: _____

Schedule: Days of treatment: _____ Days of rest: _____

Anticipated duration: _____ Other: _____

Consent signed: [ ] Yes [ ] No Note: _____

FINANCIAL

[ ] Prescription without financial difficulty.

[ ] Prescription is not filled and referred to: _____

[ ] Other: _____

SUBJECTIVE/ OBJECTIVE

Performance Status:

_____ _____

Psychosocial Assessment:

_____

Baseline Symptom Assessment:

_____

Other:

_____

Patient is able to swallow pills: [ ] Yes [ ] No Note: _____

Patient is able to open pill container: [ ] Yes [ ] No Note: _____

Medication Reconciliation:

Medications currently taking to include over the counter and alternative drugs

[ ] No changes

[ ] EHR updated with changes Note: _____

Initial Oral Cancer Therapy Intake

Name: _____
MRN: _____
DOB: _____

Drug/Drug Interaction Review:

[ ] Yes Reviewed by: _____ [ ] No/Unknown Note: _____

ASSESSMENT/ PLAN

Psychosocial:

_____

Symptom:

_____

Other:

_____

Medication Adherence:

_____

Instructions:

[ ] Patient instructed how to recognize symptoms and initiate self-management.

[ ] Patient instructed to call the practice with any problems/difficulties or questions.

[ ] Other: _____

Disposition:

[ ] Patient understands the treatment plan

[ ] At/or returned home [ ] Education completed [ ] Other: _____

Follow Up:

[ ] Labs: _____

[ ] Appointments: _____

[ ] Phone calls: _____

[ ] Other: _____

Clinician name: _____ Date: _____

Time Spent: _____

Modality: [ ] In person [ ] Phone