Education Oral Chemotherapy Template

Name: _____
MRN: _____
DOB: _____

DIAGNOSIS

Diagnosis: _____

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

ORAL CANCER THERAPY

Generic/Brand names: _____ _____

Order date: _____ Start date: _____

Schedule: Days of treatment: _____Days of rest: _____

Anticipated duration: _____Other: _____

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

SUBJECTIVE/ OBJECTIVE

Participants: [ ] Patient [ ] Support person: _____

Support person contact information: _____

Language:

Primary language: [ ] English [ ] Spanish Other: _____

Interpreter required: [ ] No [ ] Yes Note: _____

_____

Barriers:

[ ] None

[ ] Physical: _____ [ ] Cognitive:_____ [ ] Emotional: _____

[ ] Other: _____

Preferred method of learning:

[ ] Listening [ ] Reading [ ] Demonstration [ ] Pictures/Video [ ] Other: _____

Education Provided:

[ ] Written drug information provided and reviewed with the patient:

[ ] Indications

[ ] Schedule

[ ] Start date

[ ] Long-term and short-term adverse effects, including infertility risks

[ ] Side effects and toxicities

[ ] Food interactions

[ ] Drug/Drug interactions

Education Oral Chemotherapy Template

Name: _____
MRN: _____
DOB: _____

[ ] What to do if a dose is missed

[ ] Safe handling instructions: administration, storage, spills, body fluid management, environment

[ ] Contact information given: weekday, after hours, weekend, and emergency numbers

[ ] Instructed the patient to call the clinic/practice if experiencing any side effects or toxicities or difficulties with filling the prescription

[ ] Communication plan of start date to practice: [ ] Mailer [ ] Call [ ] Other: _____

ASSESSMENT/PLAN

Barriers Addressed:

_____

Evaluation: Per [ ] Patient [ ] Support person

[ ] Comprehends [ ] Developing knowledge [ ] No comprehension [ ] Refused teaching

[ ] Other: _____

Disposition: [ ] Reteach [ ] Reinforce [ ] Practice [ ] Referral to _____

[ ] Patient and/or support person agree that all questions were answered to their satisfaction

[ ]Other: _____

Follow Up:

[ ] Labs: _____

[ ] Appointments: _____

[ ] Phone calls: _____

[ ] Other: _____

Clinician name: _____Date: _____

Time Spent: _____

Modality: [ ] In person [ ] Phone