MOQC
MICHIGAN ONCOLOGY QUALITY CONSORTIUM

Patient Assessment Tool for Oral Chemotherapy

Date: ________________ Oral Chemo ID#:______________

Edmonton Symptom Assessment System:
(ESAS-r)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Well Being *(Well being = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No Constipation	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Constipation
No Diarrhea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Diarrhea
No Tingling/Numbness	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tingling/Numbness
No Mouth Sores	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Mouth Sores
No Rash	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Rash

Patient's Name ________________________________ Drug name: ____________________
Date ____________________ Time ______________

Completed by (check one):
☐ Patient
☐ Health care professional caregiver
☐ Family caregiver
☐ Caregiver-assisted
☐ Caregiver-assisted

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Patient Assessment Tool for Oral Chemotherapy

Date: __/__/__ Patient Initials: _______________ MRN: ___________________ Oral Chemo ID#________________

- What is/are the most bothersome symptom(s) you are having that you think is/are from the medicine you're taking to treat your cancer?
  ____

- How confident are you that you can manage the above symptom(s) yourself (by either modifying diet, exercise, sleep or other factors or by taking over-the-counter or prescription medications to help)? Circle below.

  I am not confident 0 1 2 3 4 5 6 7 8 9 10 I am confident

- How confident are you that you can tell when you need to seek medical care for a symptom(s) you are having? Circle below.

  I am not confident 0 1 2 3 4 5 6 7 8 9 10 I am confident

- Thinking about the last 4 weeks, please rate your ability to take your oral cancer medicine as prescribed (circle below).
  A) Excellent
  B) Very Good
  C) Good
  D) Fair
  E) Poor

- There are many reasons people are not able to take their oral cancer medicine. Thinking specifically about your oral medicine, which of the following reasons for not taking your medicine apply to you? (choose all that affect you)
  - ☐ I experienced side effects from this medicine
  - ☐ I did not have the money to pay for the medicine
  - ☐ I do not think I need this medication anymore
  - ☐ I do not think that this medicine is working for me
  - ☐ I have concerns about possible side effects from this medicine
  - ☐ I have concerns about long term effects from this medicine
  - ☐ I did not have the medicine because the pharmacy was out of this medicine
  - ☐ I have trouble managing all the medicines I take
  - ☐ I would have taken it but simply missed it
  - ☐ I would have taken it but missed it because of a busy schedule
  - ☐ I would have taken it but have problems forgetting things in my daily life
  - ☐ Other

- Rate the likelihood of completing this form at home if it were sent to you via the patient portal? Circle below.

  Not likely 0 1 2 3 4 5 Very likely