



**Aintree Holistic
Needs Assessment**
Diagnosis



Date

Name

Hospital/NHS Number

Diagnosis Date:

Diagnosis:

Pathway Point:

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Overall level of distress during the last seven days:



Cause of Cancer

- Lifestyle issues (smoking/alcohol)
- HPV Other

Multi-Disciplinary Team

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

- | | | | | | |
|------------------------------------|--|--|--|--|--|
| <input type="checkbox"/> Dietician | <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Nursing Staff | <input type="checkbox"/> Chaplain | <input type="checkbox"/> Occupational Therapist | <input type="checkbox"/> Clinical Nurse Specialist |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> Physiotherapist | <input type="checkbox"/> Financial Advisor | <input type="checkbox"/> Emotional Support Therapist | <input type="checkbox"/> Oncologist/Radiotherapist |
| <input type="checkbox"/> Surgeon | <input type="checkbox"/> Dental Hygienist | <input type="checkbox"/> Audiologist | <input type="checkbox"/> Social Worker | <input type="checkbox"/> Speech and Language Therapist | <input type="checkbox"/> Oral Rehabilitation Team |

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

- | | |
|---|---|
| <input type="checkbox"/> Appearance | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Mood |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self esteem |
| <input type="checkbox"/> Coping | <input type="checkbox"/> Sexuality |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Spirituality and religious aspects |
| <input type="checkbox"/> Intimacy | <input type="checkbox"/> Personality and temperament |
| <input type="checkbox"/> Fear of adverse events | |

Physical and Functional Well-being

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



Getting it right
for every patient
every time

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:

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