



**Pan-Canadian Oncology Symptom Triage and Remote Support  
(COSTaRS) Project**

**Remote Symptom Protocols for  
Individuals Undergoing Cancer Treatments**

**March 2012**

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Stacey D for the Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Steering Committee. Remote Symptom Protocols for Individuals Undergoing Cancer Treatment. University of Ottawa School of Nursing and the Canadian Partnership Against Cancer, Ottawa, Ontario, Canada, March 2012.

If you translate any of this material into languages other than English or French, we would appreciate that you notify Dawn Stacey RN, PhD, University of Ottawa.

## **Disclaimer**

These COSTaRS Remote Symptom Protocols for Individuals Undergoing Cancer Treatments are intended for use by trained Registered Nurses (RNs). They provide general guidance on appropriate practice and their use is subject to the registered nurses' judgment in each individual case. The COSTaRS Remote Symptom Protocols for Individuals Undergoing Cancer Treatments are designed to provide information to assist decision-making and are not meant to be prescriptive. Individuals who use these protocols are required to make their own determination regarding specific safe and appropriate clinical practices. While care has been taken to ensure that these protocols reflect the state of general knowledge and expert consensus about practice in the field at the date of publication, neither the COSTaRS Steering Committee nor the Canadian Partnership Against Cancer who funded this project make any warranty or guarantee in respect to any of the contents or information contained in these protocols. Neither group accept responsibility or liability whatsoever for any errors or omissions in these protocols, regardless of whether those errors or omissions were made negligently or otherwise.

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# Constipation Protocol

## Remote Assessment, Triage, and Management of Constipation in Adults Undergoing Cancer Treatment

Name  
Date of Birth  
Sex  
Hospital card number

Constipation: A decrease in the passage of formed stool characterized by stools that are hard and difficult to pass.<sup>1</sup>

Date and Time

### 1. Assess severity of the constipation (Supporting evidence: 1/2 guidelines)

Tell me what number from 0 to 10 best describes your constipation

No constipation    0   1   2   3   4   5   6   7   8   9   10   Worst possible constipation <sup>ESAS</sup>

How worried are you about your constipation?

Not worried    0   1   2   3   4   5   6   7   8   9   10   Extremely worried

#### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>3</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about constipation (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How many days has it been since you had a bowel movement? <sup>2</sup>	≤ 2 days	<input type="checkbox"/>	3 days or more	<input type="checkbox"/>	3 days or more on meds	<input type="checkbox"/>
Are you currently taking medication to help relieve your constipation?	No	<input type="checkbox"/>	Yes, intermittently	<input type="checkbox"/>	Yes, regularly	<input type="checkbox"/>
Do you have any abdominal pain? <sup>2</sup> Describe.	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Is your abdomen bigger than normal? <sup>2</sup> Does it feel harder than normal? <input type="checkbox"/> Unsure	None	<input type="checkbox"/>	Increasing	<input type="checkbox"/>	Severe, rigid	<input type="checkbox"/>
Have you had any nausea/lack of appetite or have you vomited? <sup>1,2</sup>	No	<input type="checkbox"/>	Nausea/lack of appetite	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>
If you vomited, did it smell like stool? <sup>2</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you recently had abdominal surgery? <sup>2</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you noticed any change in your sense of touch (numbness, tingling, burning)?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have new weakness in your arms or legs? <sup>2</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you noticed a change in your urination pattern (voiding you can't control or feeling like you can't empty your bladder)?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your constipation interfere with your daily activities at home and/or at work? Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>

1 **Mild**                     
 2 **Moderate**                     
 3 **Severe**

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/2 guidelines)

<input type="checkbox"/> Review self-care. Verify medication use, if appropriate.	<input type="checkbox"/> Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> If 1 or more symptoms present with any constipation, seek medical attention immediately.
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If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional comments:**

### 3. Review medications patient is using for constipation, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 1/2 guidelines)

Current use	Medications for constipation*	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	senna (Senokot®) <sup>1</sup>		Expert Opinion
<input type="checkbox"/>	docusate sodium (Colace®) <sup>1</sup>		Expert Opinion
<input type="checkbox"/>	Suppositories** (Dulcolax®/bisacodyl, glycerin) <sup>1</sup>		Expert Opinion
<input type="checkbox"/>	Golytely® <sup>1</sup>		Expert opinion + Low level evidence
<input type="checkbox"/>	Lactulose <sup>1</sup>		Expert Opinion
<input type="checkbox"/>	magnesium hydroxide (Milk of magnesia®) <sup>1</sup>		Expert Opinion

\*Opioid-induced constipation must be considered. Inadequate/limited evidence for cancer-treatment related constipation.

\*\* Verify blood count before using suppositories.

### 4. Review self-management strategies (Supporting evidence: 1/2 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you are constipated? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is your normal bowel routine? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink fluids, 8 glasses per day, especially warm or hot fluids? <sup>1</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you increased the fiber in your diet?(Only appropriate if adequate fluid intake and physical activity) <sup>1</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a comfortable, quiet, private environment for going to the bathroom? <sup>1</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have easy access to a toilet or bedside commode, and any necessary assistive devices (raised toilet seat)? If possible, try to avoid the use of a bedpan. <sup>1</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding non-sterilized corn syrup and castor oil? <sup>1</sup> (Corn syrup can be a source of infection; castor oil can cause severe cramping)
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a low neutrophil count are you trying to avoid rectal exams, suppositories, enemas? <sup>1</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a doctor or pharmacist about medications you may be taking that can be constipating? <sup>1</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a dietitian? <sup>1</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

1. Woolery, M., Bisanz, A., Lyons, H. F., Gaido, L., Yenulevich, M., et al. (2008). Putting evidence into practice: Evidence-based interventions for the prevention and management of constipation in patients with cancer. *Clinical Journal of Oncology Nursing*, 12(2), 317-337. (AGREE Rigour score 80%)
2. Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: <http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf>. (AGREE Rigour score 11%)
3. Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton symptom assessment system (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991; 7(2):6-9.
4. National Institutes of Health: National Cancer Institute. (2010). Common terminology criteria for adverse events (CTCAE) v4.03. Retrieved from: <http://evs.nci.nih.gov/ftp1/CTCAE/About.html>.

# Depression Protocol

## Remote Assessment, Triage, and Management of Depression in Adults Undergoing Cancer Treatment

Name  
Date of Birth  
Sex  
Hospital card number

Depression: a range of feelings and emotions from normal sadness to chronic, depressed emotional affect including clinical depression using criteria for a psychiatric disorder<sup>3</sup>; feelings of despair, hopelessness

Date and Time

### 1. Assess severity of the depression (Supporting evidence: 2/2 guidelines)

Tell me what number from 0 to 10 best describes how depressed you are feeling

Not depressed    0   1   2   3   4   5   6   7   8   9   10    Worst possible depression <sup>ESAS</sup>

How worried are you about feeling depressed?

Not worried    0   1   2   3   4   5   6   7   8   9   10    Extremely worried

Are there any concerns contributing to your feelings of depression (e.g. life events, sleep deprivation, financial problems)

Yes  No Specify: \_\_\_\_\_

### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>1,2,3</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about depression (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Have you felt depressed or had a loss of pleasure for at least 2 weeks almost all day, every day? <sup>2,3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you experienced any of the following for 2 weeks or longer (circle): feeling worthless, feeling guilty, sleeping too little or too much, weight gain or weight loss? <sup>2,3</sup>	None	<input type="checkbox"/>	2 present	<input type="checkbox"/>	4 present	<input type="checkbox"/>
Does feeling depressed interfere with your daily activities at home and/or at work? <sup>2</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significant	<input type="checkbox"/>
Have you felt tired or fatigued? <sup>2,3</sup> Describe.	No/Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Have you felt agitated (which may include twitching or pacing) or slowing down of your thoughts? <sup>2,3</sup>	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, severe	<input type="checkbox"/>
Do you have any other risk factors such as (circle): bothersome symptoms, a lack of social support, a history of depression or substance abuse, living alone, recurrent/advanced disease, younger age (< 30)? <sup>2</sup>	None	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, several	<input type="checkbox"/>

 <b>1 Mild</b>	 <b>2 Moderate</b>	 <b>3 Severe</b>
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### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/2 guidelines)

<input type="checkbox"/> Review self-care. Verify medication use, if appropriate.	<input type="checkbox"/> Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> Have you had recurring thoughts of dying, trying to kill yourself or harming yourself? <sup>2,3</sup> If yes, immediate referral for further evaluation. <input type="checkbox"/> If no, and 1 or more symptoms present with any depression, seek non-urgent medical attention. Review self-care. Verify medication use, if appropriate.
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If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for depression, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2/2 guidelines)

Current use	Medications for depression*	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	SSRIs - fluoxetine (Prozac <sup>®</sup> ), sertraline (Zoloft <sup>®</sup> ), paroxetine (Paxil <sup>®</sup> ), citalopram (Celexa <sup>®</sup> ), fluvoxamine (Luvox <sup>®</sup> ), escitalopram (Lexapro <sup>®</sup> ) <sup>3</sup>		Systematic review
<input type="checkbox"/>	Tricyclic antidepressants - amitriptyline (Elavil <sup>®</sup> ), imipramine (Tofranil <sup>®</sup> ), desipramine (Norpramin <sup>®</sup> ), nortriptyline (Pamelor <sup>®</sup> ), doxepin (Sinequan <sup>®</sup> ) <sup>3</sup>		Systematic review

\*Use of antidepressant depends on side effect profiles of medications and the potential for interaction with other current medications.

### 4. Review self-management strategies (Supporting evidence: 2/2 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel depressed? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. <sup>2</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)? <sup>2</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in any support groups <sup>2,3</sup> and/or have family/friends you can rely on for support?
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation therapy or guided imagery? <sup>2,3</sup> (systematic review with meta-analysis)
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive-behavioural therapy or received personal counseling that provides more in-depth guidance on managing depression? <sup>2,3</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

- Bruera E, Kuehn N, Miller MJ, Selmsler P, Macmillan K. The Edmonton symptom assessment system (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991; 7(2):6-9.
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- Fulcher CD, Badger T, Gunter AK, Marrs JA, Reese JM. (2008, Feb). Putting Evidence Into Practice: Interventions for Depression. *Clinical Journal of Oncology Nursing*, 12(1), 131-140. (AGREE rigour score 43.8%)

# Diarrhea Protocol

## Remote Assessment, Triage, and Management of Diarrhea in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Hospital card number \_\_\_\_\_

**Diarrhea:** An abnormal increase in stool liquidity and frequency over baseline (> 4-6 stools/day) which may be accompanied by abdominal cramping.<sup>3,5</sup>

Date and Time \_\_\_\_\_

### 1. Assess severity of the diarrhea (Supporting evidence: 6/6 guidelines)

Tell me what number from 0 to 10 best describes your diarrhea

No diarrhea 0 1 2 3 4 5 6 7 8 9 10 Worst possible diarrhea <sup>ESAS</sup>

How worried are you about your diarrhea?

Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

Have you been tested for c-difficile? If yes, do you know the results?

Yes  No  Unsure Results \_\_\_\_\_

#### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>8</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about diarrhea (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Think about your normal bowel pattern. How many extra bowel movements are you having per day (including at night), above what is normal for you? <sup>2,3,5,6</sup>	< 4 stools	<input type="checkbox"/>	4-6 stools	<input type="checkbox"/>	≥ 7 stools	<input type="checkbox"/>
Ostomy: How much extra output are you having, above what is normal for you? <sup>2,3,5,6</sup>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Do you have a fever > 38° C? <sup>2,3,5,6</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have pain in your abdomen or rectum with or without cramping or bloating? <sup>2,5,6</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any blood in your stool or is it black? <sup>2,5,6</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your diarrhea interfere with your daily activities at home and/or at work? <sup>2,5</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Have you vomited and/or had moderate nausea? <sup>2,3,5,6</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine? <sup>2,3,5,6</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you been able to drink fluids? <sup>5,6</sup>	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>



**Mild**



**Moderate**



**Severe**

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: ½ guidelines)

Review self-care. Verify medication use, if appropriate.

Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

If 1 or more symptoms present with any diarrhea, seek medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**



### 3. Review medications patient is using for diarrhea, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 5/6 guidelines)

Current use	Medications for diarrhea	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	Loperamide (Imodium <sup>®</sup> ) <sup>2,3,4,5</sup>		Systematic Review
<input type="checkbox"/>	Atropine-diphenoxylate (Lomotil <sup>®</sup> ) <sup>3,4,5</sup>		Systematic Review
<input type="checkbox"/>	Octreotide (Sandostatin <sup>®</sup> ) <sup>1,2,3,4,5</sup>		Systematic Review
<input type="checkbox"/>	Psyllium fiber (Metamucil <sup>®</sup> ) <sup>3</sup>		Randomized control trial

### 4. Review self-management strategies (Supporting evidence: 5/6 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have diarrhea? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 8-10 glasses clear fluids per day (e.g. water, sports drinks, broth)? <sup>2,3,4,5,6</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what kinds of foods you should be trying to eat? Suggest: applesauce, oatmeal, bananas, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned turkey or chicken, mashed potatoes, cooked or canned fruit without skin <sup>2,3,4,5,6</sup> (Foods high in soluble fiber and low in insoluble fiber)
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to replace electrolytes (eg. potassium and sodium or salt) that your body may be losing with the diarrhea by eating foods such as bananas and potatoes and drinking sports drinks or peach/apricot nectar? <sup>3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat 5-6 small meals? <sup>2,3,5,6</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid lactose-containing products (milk, yoghurt, cheese) <sup>2,3,5,6</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid alcohol and minimize caffeine (<2-3 servings) (coffee, chocolate) <sup>2,3,4,5,6</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid greasy/fried and spicy foods? <sup>3,5,6</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid large amounts fruit juices or sweetened fruit drinks? <sup>2,3</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes? <sup>3,5,6</sup> (Insoluble fiber)
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to keep skin around your rectum or ostomy clean to avoid skin breakdown? <sup>5</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been keeping track of the number of stools you are having and are you aware of other problems you should be watching for with your diarrhea? (e.g. fever, dizziness) <sup>2,5</sup> (review criteria listed above in assessment)
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a doctor or pharmacist about medications you may be taking that can cause or worsen your diarrhea? <sup>5</sup>

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

- Major, P., Figueroa, A., Tandan, V., Bramwell, V., Charette, M., Oliver, T., et al. (2004). The role of octreotide in the management of patients with cancer. Practice guideline report #12-7. Cancer Care Ontario. Retrieved from: <https://www.cancercare.on.ca/toolbox/qualityguidelines/clin-program/systemic-ebis/>. (AGREE Rigour score 86%)
- Benson, A.B., III, Ajani, J.A., Catalano, R.B., Engelking, C., Kornblau, S.M., Martenson, J.A., Jr., et al. (2004). Recommended guidelines for the treatment of cancer treatment-induced diarrhea. *Journal of Clinical Oncology*, 22(14), 2918-2926. (AGREE Rigour score 73%)
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- British Columbia Cancer Agency. (2004). BCCA Guidelines for management of chemotherapy-induced diarrhea. Retrieved from: <http://www.bccancer.bc.ca/HPI/CancerManagementGuidelines/SupportiveCare/Chemotherapy-Induced+Diarrhea.htm>. (AGREE Rigour score 17%)
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- Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: <http://www.onlta.on.ca/library/repository/mon/9000/245778.pdf>. (AGREE Rigour score 11%)
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# Fatigue/Tiredness Protocol

## Remote Assessment, Triage, and Management of Fatigue/Tiredness in Adults Undergoing Cancer Treatment

Name  
Date of Birth  
Sex  
Hospital card number

**Fatigue:** a subjective feeling of tiredness or exhaustion prompted by cancer or cancer treatment that is disproportionate to the level of recent exertion, is not relieved by rest and interferes with usual daily activities.<sup>1</sup>

Date and Time

### 1. Assess severity of the fatigue/tiredness (Supporting evidence: 3/3 guidelines)




Tell me what number from 0 to 10 best describes how tired you are feeling

Not tired    0   1   2   3   4   5   6   7   8   9   10   Worst possible tiredness<sup>ESAS</sup>

How worried are you about your fatigue/tiredness?

Not worried    0   1   2   3   4   5   6   7   8   9   10   Extremely worried

#### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>1,2</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about fatigue (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Do you have the following: shortness of breath at rest, sudden onset of severe fatigue, excessive need to sit or rest, rapid heart rate, rapid blood loss, or pain in your chest?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How would you describe the pattern of fatigue?	Intermittent	<input type="checkbox"/>		<input type="checkbox"/>	Constant/ Daily for two weeks	<input type="checkbox"/>
Does your fatigue interfere with your daily activities at home and/or at work? Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Are there times when you feel exhausted? Describe.	No	<input type="checkbox"/>	Yes, intermittently	<input type="checkbox"/>	Yes, constantly for two weeks	<input type="checkbox"/>
	 <b>1</b> Mild		 <b>2</b> Moderate		 <b>3</b> Severe	

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/2 guidelines)

<input type="checkbox"/> Review self-care.	<input type="checkbox"/> Review self-care. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> If 1 or more symptoms present with any fatigue/tiredness, seek medical attention immediately. *If severe fatigue is stabilized, review self-management strategies.
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If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for fatigue, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3/3 guidelines)

Current use	Medications for fatigue	Notes	Type of Evidence
<input type="checkbox"/>			

\*Use of pharmacological agents for cancer-related fatigue is experimental and NOT recommended (e.g. psycho-stimulants, sleep medications, low dose corticosteroids) unless for select patients at end of life with severe fatigue

### 4. Review self-management strategies (Supporting evidence: 3/3 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel fatigued/tired? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you understand what cancer-related fatigue is? Provide education about how it differs from normal fatigue, that it is expected with cancer treatment
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you monitoring your fatigue levels?
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to save energy for things that are important to you?
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What are you doing for physical activity? Moderate level of physical activity during and after cancer treatment is encouraged (e.g. 30 min of moderate intensity activity most days of the week: fast walk, cycle, swim, resistance exercise) *Use with caution in patients with some conditions (ie. bone metastases)
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you think you are eating/drinking enough to meet your body's energy needs?
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried activities such as reading, games, music, gardening, experiences in nature?
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in any support groups and/or have family/friends you can rely on for support?
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried activities to make you more relaxed? Such as relaxation therapy, deep breathing, yoga, guided imagery, or massage therapy? (3 RCT's sessions lowered fatigue scores)
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you done any of the following to improve the quality of your sleep? Avoid long or late afternoon naps; limit time in bed to actual sleep; go to bed when sleepy; use bed for sleep and sexual activity only; have consistent schedule for bedtime and getting up; avoid caffeine and stimulating activity in the evening; relax for 1 hour before going to bed; establish a bedtime routine
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with or would you like to speak with a health care professional to help guide you in managing your fatigue? (physiotherapist, occupational therapist, dietitian)
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive behavioural therapy to manage your fatigue?

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

- Howell D, Keller-Olaman S, Oliver TK, et al., (2012, in press) A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Cancer-Related Fatigue in Adults with Cancer. Canadian Partnership Against Cancer: The National Advisory Working Group on behalf of the Cancer Journey Portfolio.  
Other guidelines referenced within this guideline are:
  - Oncology Nursing Society (ONS). Putting Evidence into Practice (PEP) Topics – Fatigue. Accessed December 2009. Retrieved from: <http://www.ons.org/Research/PEP/Fatigue>. (AGREE rigour score 55.2%)
  - Clinical Practice Guidelines in Oncology – Cancer-Related Fatigue, V.2.2009 (June 2009), National Comprehensive Cancer Network (NCCN). Retrieved from: [http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp). (AGREE rigour score 28.5%)
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# Febrile Neutropenia Protocol

## Remote Assessment, Triage, and Management of Febrile Neutropenia in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_  
 Sex \_\_\_\_\_  
 Hospital card number \_\_\_\_\_

**Fever:** A single oral temperature of  $\geq 38.3^{\circ}\text{C}$  ( $101^{\circ}\text{F}$ ) or a temperature of  $\geq 38.0^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ) for  $\geq 1$  hour.

**Neutropenia:** A neutrophil count of  $< 500$  cells/ $\text{mm}^3$  or a count of  $< 1000$  cells/ $\text{mm}^3$  with a predicted decrease to  $< 500$  cells/ $\text{mm}^3$ .

**Febrile neutropenia:** A neutrophil count of  $< 1000$  cells/ $\text{mm}^3$  and a single oral temperature of  $\geq 38.3^{\circ}\text{C}$  ( $101^{\circ}\text{F}$ ) or a temperature of  $\geq 38.0^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ) for  $\geq 1$  hour.

Date and Time \_\_\_\_\_

### 1. Assess severity of the fever and neutropenia (Supporting evidence: 4/4 guidelines)

How worried are you about your fever?

Not worried    0   1   2   3   4   5   6   7   8   9   10    Extremely worried

What is your temperature in the last 24 hours? Current: \_\_\_\_\_ Previous temperatures: \_\_\_\_\_

Have you taken any acetaminophen (Tylenol<sup>®</sup>) or ibuprofen (Advil<sup>®</sup>), if yes, how much and when? \_\_\_\_\_

#### Ask patient to indicate which of the following are present or absent

Temperature of $\geq 38.0^{\circ}\text{C}$ ( $100.4^{\circ}\text{F}$ )? <sup>1,2,3,4,5</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Last known neutrophil count <sup>1,2,3,5</sup> _____ Date: _____ <input type="checkbox"/> Unsure	$>1000$ cells/ $\text{mm}^3$	<input type="checkbox"/>	$<500$ cells/ $\text{mm}^3$ or 1000 cells/ $\text{mm}^3$ with expected drop	<input type="checkbox"/>
Have you received either chemotherapy or radiation treatment within the past 1-4 weeks? <sup>4</sup>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>

**1** Mild

**3** Severe

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/4 guidelines)

Review self-care.

If fever with known or suspected neutropenia, in addition to any other symptoms, seek medical attention immediately.

Note: Although guidelines indicate the need to take action when a temperature is  $\geq 38.3^{\circ}\text{C}$  ( $101^{\circ}\text{F}$ ) at any time or a temperature is  $\geq 38.0^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ) for  $\geq 1$  hour, for consistency across symptom protocols a temperature of  $38.0^{\circ}\text{C}$  is used.

**Additional Comments:**

### 3. Review medications patient is using for fever, including prescribed, over the counter, and/or herbal supplements

Current use	Medications	Notes	Type of Evidence
<input type="checkbox"/>			

\*Use of medications to lower fever in cancer patients is controversial and should not be used to mask a fever of unknown origin.

### 4. Review self-management strategies to minimize risk of infection (Supporting evidence: 1/4 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you washing your hands frequently? <sup>4</sup>
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to increase your fluid intake to 8-12 glasses per day? <sup>4</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you brushing your teeth with a soft toothbrush? <sup>4</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid enemas, suppositories, tampons and invasive procedures? <sup>4</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to keep any wounds clean and dry? <sup>4</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid crowds and people who might be sick? <sup>4</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

- Hughes, W. T., Armstrong, D., Bodey, G. P., Bow, E. J., Brown, A. E., et al. (2002). 2002 Guidelines for the use of antimicrobial agents in neutropenic patients with cancer. *Clinical Infectious Diseases*, 34, 730-751. (AGREE Rigour score 62%)
- National Comprehensive Cancer Network. (2008). NCCN Clinical practice guidelines in oncology: Prevention and treatment of cancer-related infections. Version 1. Retrieved from: [http://www.nccn.org/professionals/physician\\_gls/f\\_guidelines.asp](http://www.nccn.org/professionals/physician_gls/f_guidelines.asp). (AGREE Rigour score 48%)
- Mendes, A., Sapolnik, R. & Mendonça, N. (2007). New guidelines for the clinical management of febrile neutropenia and sepsis in pediatric oncology patients. *Journal de Pediatria*, 83(Supp 2), 54-63. (AGREE Rigour score 33%)
- Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: <http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf>. (AGREE Rigour score 11%)
- National Institutes of Health: National Cancer Institute. (2010). Common terminology criteria for adverse events (CTCAE) v4.03. Retrieved from: <http://evs.nci.nih.gov/ftp1/CTCAE/About.html>.

# Loss of Appetite Protocol

## Remote Assessment, Triage, and Management of Loss of Appetite in Adults Undergoing Cancer Treatment

Name  
Date of Birth  
Sex  
Hospital card number

Anorexia: An involuntary loss of appetite<sup>1</sup>; being without appetite.

Date and Time

### 1. Assess severity of the anorexia (Supporting evidence: 1/3 guideline)

Tell me what number from 0 to 10 best describes your appetite

Best appetite    0   1   2   3   4   5   6   7   8   9   10   Worst possible appetite <sup>ESAS</sup>

How worried are you about your poor appetite?

Not worried    0   1   2   3   4   5   6   7   8   9   10   Extremely worried

#### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>4</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about poor appetite (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How much have you had to eat and drink in past 24 hours (eg. at each meal)? <sup>3</sup>	Some	<input type="checkbox"/>	Minimal	<input type="checkbox"/>	None	<input type="checkbox"/>
Does your poor appetite interfere with your daily activities at home and/or at work? <sup>3</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine? <sup>3</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you lost weight in the last 1-2 weeks? Amount: <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		

**1** Mild

**2** Moderate

**3** Severe

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/3 guidelines)

Review self-care. Verify medication use, if appropriate.

Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.

If 1 or more symptoms present with any anorexia, seek medical attention immediately.  
\*If severe loss of appetite is stabilized, review self-management strategies.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional comments:**

### 3. Review medications patient is using for anorexia, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 1/3 guideline)

Current use	Medications for appetite	Notes (eg. dose, suggest taking as prescribed)	Type of Evidence
<input type="checkbox"/>	Corticosteroids - dexamethasone (Decadron <sup>®</sup> ), prednisone <sup>1</sup>		Systematic review
<input type="checkbox"/>	megestrol (Megace <sup>®</sup> ) <sup>1</sup>		Systematic review

### 4. Review self-management strategies (Supporting evidence: 3/3 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel like you are not hungry? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat 5-6 small meals? <sup>3</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat more when you feel most hungry? <sup>3</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat foods that are higher in protein and calories such as cheese, yogurt, eggs, or milk shakes? <sup>3</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using any food supplements (Ensure, Glucerna, Boost <sup>®</sup> )? <sup>1</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to limit drinking ½ hour before a meal to avoid feeling too full? <sup>3</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Did you know that cold foods are sometimes better tolerated? <sup>3</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to sit up after each meal for 30-60 minutes to help digest your food? <sup>3</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a dietitian? <sup>1,2</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

- Adams, L. A., Shepard, N., Caruso, R., Norling, M. J., Belansky, H., & Cunningham, R. S. (2009). Putting evidence into practice: Evidence-based interventions to prevent and manage anorexia. *Clinical Journal of Oncology Nursing*, 13(1), 95-102. (AGREE Rigour score 83%)
- Dy, S. M., Lorenz, K. A., Naeim, A., Sanati, H., Walling, A. and Asch, S. M. (2008). Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. *Journal of Clinical Oncology*, 26(23), 3886-3895. (AGREE Rigour score 51%);
- Cancer Care Ontario. (2004). Telephone nursing practice and symptom management guidelines. Retrieved from: <http://www.ontla.on.ca/library/repository/mon/9000/245778.pdf>. (AGREE Rigour score 11%)
- Bruera E, Kuehn N, Miller MJ, Selmser P, Macmillan K. The Edmonton symptom assessment system (ESAS): a simple method for the assessment of palliative care patients. *J Palliat Care* 1991; 7(2):6-9.

# Mouth Sores/Stomatitis Protocol

## Remote Assessment, Triage, and Management of Mouth Sores/Stomatitis in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name  
Date of Birth  
Sex  
Hospital card number

Mouth sores/Stomatitis/Oral Mucositis: An inflammatory and potentially ulcerative process of the mucous membranes, resulting in severe discomfort that can impair patients' ability to eat, swallow, and talk, and is accompanied by a risk for life-threatening bacteremia and sepsis.<sup>2</sup>

Date and Time

### 1. Assess severity of the mouth sores (Supporting evidence: 4/4 guidelines)

Tell me what number from 0 to 10 best describes your mouth sores?

No mouth sores    0   1   2   3   4   5   6   7   8   9   10   Worst possible mouth sores<sup>5</sup>

How worried are you about your mouth sores?

Not worried    0   1   2   3   4   5   6   7   8   9   10   Extremely worried

#### Ask patient to indicate which of the following are present or absent

Patient rating (see above)	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about mouth sores (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How many sores/ulcers/blisters do you have? <sup>2,3,4</sup>	0-4	<input type="checkbox"/>	>4	<input type="checkbox"/>	Coalescing/ Merging/Joining	<input type="checkbox"/>
Do the sores in your mouth bleed? <sup>2,3,4</sup>	No	<input type="checkbox"/>	Yes, with eating or oral hygiene	<input type="checkbox"/>	Yes, spontaneously	<input type="checkbox"/>
Are the sores painful? <sup>1,2,3,4</sup>	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Are you able to eat and drink? <sup>2,3,4</sup>	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
Are you having trouble breathing? <sup>4</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>



**Mild**



**Moderate**



**Severe**

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/4 guidelines)

Review self-care. Verify medication use, if appropriate.

Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

If 1 or more symptoms present with any mouth sores, seek medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**



### 3. Review medications patient is using for mouth sores, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 1/4 guidelines)

Current use	Medications for mouth sores	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	benzydamine hydrogen chloride (Tantum mouth rinse) <sup>2</sup>		1 Randomized trial

\*Many other medications have been tested however their effectiveness has not been established.

### 4. Review self-management strategies (Supporting evidence: 4/4 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have mouth sores? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to rinse your mouth 4 times a day with a bland rinse? For 1 cup warm water, add 2.5 ml (1/2 tsp.) table salt, baking soda or both. Swish 15 ml (1 tablespoon) in your mouth for at least 30 seconds and spit out. <sup>2,4</sup> Store extra solution in the fridge or at room temperature.
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to brush your teeth at least twice a day using a soft toothbrush and flossing once daily or as tolerated? <sup>1,2,4</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you wear dentures and your mouth is sensitive, do you try to use your dentures only at mealtimes? <sup>4</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using water-based moisturizers to protect your lips? <sup>2,4</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you allow your toothbrush to air dry before storing? <sup>2,4</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid tobacco and alcohol, including alcohol-based mouthwashes? <sup>2,4</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 8-10 glasses of fluids per day? <sup>2,4</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat a soft diet? Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes <sup>2,4</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid foods and drinks that are acidic, salty, spicy, or very hot (temperature)? <sup>2,4</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

- Keefe, D. M. et al. (2007). Updated clinical practice guidelines for the prevention and treatment of mucositis. *Cancer*, 109(5): 820-31. (AGREE Rigour score 82%)
- Harris, D. J., Eilers, J., Harriman, A., Cashavelly, B. J., & Maxwell, C. (2008). Putting evidence into practice: evidence-based interventions for the management of oral mucositis. *Clinical Journal of Oncology Nursing*, 12(1): 141-52. (AGREE Rigour score 79%)
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# Nausea & Vomiting Protocol

## Remote Assessment, Triage, and Management of Nausea & Vomiting in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name  
Date of Birth  
Sex  
Hospital card number

Nausea: A subjective perception that emesis may occur. Feeling of queasiness.  
Vomiting: A forceful expulsion of stomach contents through the mouth and may include retching (gastric and esophageal movement without vomiting – dry heaves.)<sup>7</sup>

Date and Time

### 1. Assess severity of nausea/vomiting (Supporting evidence: 3/7 guidelines)

Tell me what number from 0 to 10 best describes your nausea

No nausea 0 1 2 3 4 5 6 7 8 9 10 Worst possible nausea<sup>ESAS</sup>

Tell me what number from 0 to 10 best describes your vomiting?

No vomiting 0 1 2 3 4 5 6 7 8 9 10 Worst possible vomiting<sup>ESAS</sup>

How worried are you about your nausea/vomiting?




Not worried 0 1 2 3 4 5 6 7 8 9 10 Extremely worried

#### Ask patient to indicate which of the following are present or absent

Patient rating for nausea (see ESAS above) <sup>9</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating for vomiting (see ESAS above) <sup>9</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about nausea/vomiting (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
How many times per day are you vomiting or retching? <sup>8</sup> <input type="checkbox"/> No vomiting	≤1	<input type="checkbox"/>	2-5	<input type="checkbox"/>	>5	<input type="checkbox"/>
Have you been able to eat within last 24 hours? <sup>7,8</sup>	Yes	<input type="checkbox"/>	Yes, reduced	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you been able to tolerate drinking fluids? <sup>8</sup>	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine? <sup>3,7</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any blood in your vomit or does it look like coffee grounds? <sup>7</sup> <input type="checkbox"/> No vomiting	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any abdominal pain? <sup>7</sup>	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Does your nausea/vomiting interfere with your daily activities at home and/or at work? Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>

 <b>1 Mild</b>	 <b>2 Moderate</b>	 <b>3 Severe</b>
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### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 3/7 guidelines)

 <b>1 Mild</b> <input type="checkbox"/> Review self-care. Verify medication use, if appropriate.	 <b>2 Moderate</b> <input type="checkbox"/> Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	 <b>3 Severe</b> <input type="checkbox"/> If 1 or more symptoms present with any vomiting or severe nausea, seek medical attention immediately.
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If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for nausea/vomiting, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 6/7 guidelines)

Current use	Medications for nausea/vomiting	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	ondansetron (Zofran <sup>®</sup> ), granisetron (Kytril <sup>®</sup> ), dolasetron (Anszemet <sup>®</sup> ) <sup>1,2,3,4,5,6</sup>		Systematic review
<input type="checkbox"/>	metoclopramide (Maxeran <sup>®</sup> ) <sup>1,2,3,5,6</sup>		Systematic review
<input type="checkbox"/>	prochlorperazine (Stemetil <sup>®</sup> ) <sup>1,2,3,4,6</sup>		Systematic review
<input type="checkbox"/>	aprepitant (Emend <sup>®</sup> ) <sup>2,3,4,5,6</sup>		Systematic review

### 4. Review self-management strategies (Supporting evidence: 4/7 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have nausea/vomiting? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 8-10 glasses clear fluids per day (e.g. water, sports drinks, broth)? <sup>7</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation techniques that may include guided imagery, music therapy, progressive muscle relaxation? <sup>3,6</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking anti-emetic medications prior to your meals so that they are effective during and after meals? <sup>6,7</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to: - eat 5-6 small meals? <sup>7</sup> - eat foods that minimize your nausea and are your "comfort foods"? <sup>6</sup> - avoid greasy/fried, highly salty, and spicy foods? <sup>6,7</sup> - eat foods that are cold, avoiding extreme temperatures? <sup>6,7</sup> - reduce food aromas and avoid other strong odors? <sup>6,7</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried acupuncture or acupressure to help with your nausea/vomiting? <sup>3,5,6</sup> (supporting evidence: systematic review)
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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#### References

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# Peripheral Neuropathy Protocol

## Remote Assessment, Triage, and Management of Peripheral Neuropathy in Adults Undergoing Cancer Treatment

Neuropathy: Described as numbness, tingling, pins and needles, tremor, balance disturbances, pain. The end result of peripheral, motor, sensory, and autonomic neuron damage caused by neurotoxic chemotherapy agents that inactivate the components required to maintain the metabolic needs of the axon.<sup>1</sup>

Name  
Date of Birth  
Sex  
Hospital card number

Date and Time

### 1. Assess severity of the neuropathy (Supporting evidence: 3/3 guidelines)

Tell me what number from 0 to 10 best describes your neuropathy/numbness/tingling?

No neuropathy    0   1   2   3   4   5   6   7   8   9   10   Worst possible neuropathy<sup>ESAS</sup>

How worried are you about your neuropathy/numbness/tingling?

Not worried    0   1   2   3   4   5   6   7   8   9   10   Extremely worried

#### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>4</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about neuropathy (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Do you have pain in your _____ (neuropathy location)? <sup>1,2,3</sup> Describe.	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you have new weakness in your arms or legs? <sup>1,2</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you noticed problems with your balance or how you walk, if yes, how much? <sup>1,2</sup>	No/Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Are you constipated? <sup>1,2</sup>	No/Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>
Does your neuropathy/numbness/tingling interfere with your daily activities at home and/or at work (e.g. buttoning clothing, writing, holding coffee cup)? <sup>1,2</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>



**Mild**



**Moderate**



**Severe**

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/3 guidelines)

Review self-care. Verify medication use, if appropriate.

Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

If 1 or more symptoms present with any neuropathy, seek medical attention.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for neuropathy, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2/3 guidelines)

Current use	Medications for neuropathy	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	Anti-convulsants – gabapentin, pregabalin (Lyrica <sup>®</sup> ) <sup>2</sup>		Expert Opinion
<input type="checkbox"/>	Tricyclic anti-depressants – amitriptyline, nortriptyline, duloxetine (Cymbalta <sup>®</sup> ), venlafaxine (Effexor <sup>®</sup> ), bupropion (Wellbutrin <sup>®</sup> , Zyban <sup>®</sup> ) <sup>2,3</sup>		Expert Opinion
<input type="checkbox"/>	Opioids – fentanyl, morphine (Staxex <sup>®</sup> ), hydromorphone (Dilaudid <sup>®</sup> ), codeine, oxycodone <sup>2,3</sup>		Expert Opinion
<input type="checkbox"/>	Topical agent – lidocaine patch <sup>2,3</sup>		Expert Opinion

### 4. Review self-management strategies (Supporting evidence: 3/3 guidelines)

What strategies are already being used?	Strategy suggested/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps with managing your neuropathy? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you look at your hands and feet every day for sores/blisters that you may not feel? <sup>1,2</sup>
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If neuropathy in feet:</b> Do you have footwear that fits you properly? <sup>1,2</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In your home: - are the walkways clear of clutter? <sup>1,2</sup> - do you have a skid-free shower or are you using bath mats in your tub? <sup>1,2</sup> - have you removed throw rugs that may be a tripping hazard? <sup>1,2</sup>
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When you are walking on uneven ground, do you try to look at the ground to help make up for the loss of sensation in your legs or feet? <sup>1,2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>If any neuropathy:</b> To avoid burns due to decreased sensation: -Have you lowered the water temperature in your hot water heater? <sup>1</sup> -Do you use a bath thermometer to ensure water in shower or tub is < 120°F/49°C? <sup>1</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you try to dangle your legs before you stand up to avoid feeling dizzy? <sup>1,2</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you try eat a high-fiber diet and drink adequate fluids to avoid becoming constipated? <sup>1,2</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried acupuncture? <sup>2</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a physiotherapist about: - a walker, cane, or a splint to help with your balance and improve walking? <sup>1,2</sup> - a physical training plan or TENS (transcutaneous electrical nerve stimulation)? <sup>2,3</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with an occupational therapist for suggestions such as: -switching to loafer-style shoes or using Velcro shoe laces -adaptive equipment such as enlarged handles on eating utensils, button hooks, Velcro on computer keys to stimulate sensation?
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller monitoring (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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# Skin Reaction Protocol

## Remote Assessment, Triage, and Management of Skin Reactions in Adults Undergoing Cancer Treatment

(not for patients undergoing bone marrow transplant)

Name  
Date of Birth  
Sex  
Hospital card number

Skin reaction/alteration: A change in the colour, texture or integrity of the skin.<sup>2</sup>

Date and Time

### 1. Assess severity of the skin reaction (Supporting evidence: 3/3 guidelines)

Tell me what number from 0 to 10 best describes your skin reaction

No skin reaction    0   1   2   3   4   5   6   7   8   9   10   Worst possible skin reaction <sup>ESAS</sup>

How worried are you about your skin reaction?

Not worried    0   1   2   3   4   5   6   7   8   9   10   Extremely worried

Site of skin reaction(s) \_\_\_\_\_

#### Ask patient to indicate which of the following are present or absent

Patient rating (see ESAS above) <sup>3</sup>	0-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Patient rating of worry about skin reaction (see above)	0-5	<input type="checkbox"/>	6-10	<input type="checkbox"/>		
Is your skin red? <sup>1,2,4</sup>	None	<input type="checkbox"/>	Faint/dull	<input type="checkbox"/>	Tender/bright	<input type="checkbox"/>
Is your skin peeling? <sup>1,2,4</sup>	No/Dry	<input type="checkbox"/>	Patchy, moist	<input type="checkbox"/>	Generalized, moist	<input type="checkbox"/>
Do you have any swelling around the skin reaction area? <sup>1,2</sup>	No/Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Pitting	<input type="checkbox"/>
Do you have pain at the skin reaction area? <sup>2,4</sup>	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you have any ulcers? <sup>1,4</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any bleeding? <sup>1,4</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any areas of black skin or dead tissue? <sup>1,4</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any open, draining wounds? <sup>2,4</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a new rash?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? <sup>2</sup> <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you started a new medication? <sup>4</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your skin reaction interfere with your daily activities at home and/or at work? <sup>2,4</sup> Describe.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, significantly	<input type="checkbox"/>
If you have a Port-o-cath, a PICC or another kind of access device that goes directly into your blood stream, are there any signs of infection that you notice, such as redness, tenderness, discharge, or swelling at the site? <sup>2</sup>	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>

**1** Mild

**2** Moderate

**3** Severe

### 2. Triage patient for symptom management based on highest severity (Supporting evidence: 1/3 guidelines)

Review self-care. Verify medication use, if appropriate.

Review self-care. Verify medication use, if appropriate. Advised to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.

If 1 or more symptoms present with any skin reaction, seek medical attention immediately.

If patient is experiencing other symptoms, did you also refer to the appropriate protocols? If yes, please specify:

**Additional Comments:**

### 3. Review medications patient is using for skin reaction, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2/3 guidelines)

Current use	Medications for skin reaction to radiation therapy*	Notes (eg. dose, suggest to use as prescribed)	Type of Evidence
<input type="checkbox"/>	Calendula ointment <sup>1,4</sup>		1 randomized trial
<input type="checkbox"/>	Hyaluronic acid cream <sup>4</sup>		1 randomized trial
<input type="checkbox"/>	Low-dose corticosteroid cream <sup>1,4*</sup>		Expert opinion

\* There is insufficient evidence to support or refute other specific topical agents (i.e., corticosteroids, sucralfate cream, Biafine<sup>®</sup>, ascorbic acid, aloe vera, chamomile cream, almond ointment, polymer adhesive skin sealant) for the prevention of acute skin reaction.

### 4. Review self-management strategies (Supporting evidence: 3/3 guidelines)

What strategies are already being used?	Strategy suggested/education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have a skin reaction? Reinforce as appropriate. Specify:
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to take warm showers or immersion in warm baths (not soaking in the tub) using mild soap, and patting dry (no rubbing)? <sup>1,2,4</sup> (Randomized control trial evidence)
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use plain, non-scented, lanolin-free, water-based creams on intact skin only? <sup>1,2,4</sup>
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using deodorant if skin is intact? <sup>4</sup> (Randomized control trial evidence)
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 8-12 glasses of fluids per day to maintain hydration? <sup>2</sup>
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use an electric razor OR avoid shaving the area that is irritated? <sup>2,4</sup>
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding skin creams or gels in the treatment area before each treatment? <sup>4</sup>
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid chlorinated pools and Jacuzzis? <sup>2,4</sup>
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid temperature extremes in the treatment area (eg. ice pack or heating pad) to the reaction area? <sup>2,4</sup>
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to protect the treatment area from the sun and the cold? <sup>4</sup>
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid tape or Band-aids in the treatment area? <sup>2,4</sup>
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

### 5. Summarize and document plan agreed upon with caller (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advised to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
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