

LNR Psychological & Emotional Quick Screen vfinal (Feb09)

INSTRUCTIONS

This Quick Screen is simple method of identifying patient distress. Once you have received training, please help the patient to complete this page (file this in the notes) and then fill in the feedback form attached.

This is not intended to replace clinical assessment, but is a guide to assisting/managing psychological/psychiatric distress related to cancer. The NICE guidelines for supportive and palliative care in cancer recommend screening patients at: diagnosis, treatment episodes, treatment end and at time of recurrence, as a minimum.

1. PATIENT DETAILS

Stage Diagnosis In-Treatment Remission Recurrence/Late Other

Addressograph

DOB _____

M / F

UHL

KGH

NGH

Other _____

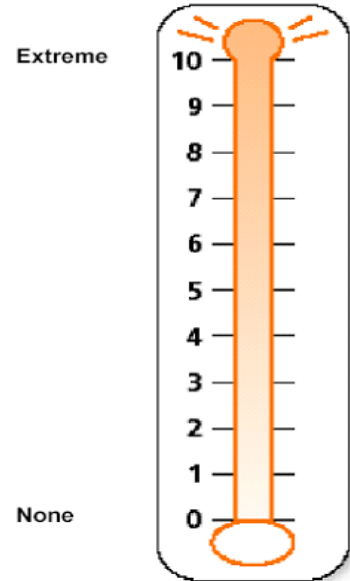
2. DISTRESS THERMOMETER

Instructions

Please ask the patient to circle the number (0-10) that best describes how much distress in general they have been experiencing over the past week

Does this score represent a significant change?

- Worse No change Better



3. CONCERNS CHECKLIST

Instructions

Please ask the patient to tick any of the following that has been a cause of distress over the past week, including today. Also ask for the most pressing concerns.

Practical Concerns

- Family Issues
- Issues with Health Staff
- Finances / Bills
- Lack of Information
- Problems with medication
- Others

Personal Concerns

- Appearance
- Self-care
- Loss of Independence
- Loss or Role
- Sexual/Intimacy Issues
- Spiritual issues

(1st) Most Pressing

Emotional Concerns

- Anger / irritability
- Nervousness / anxiety
- Depression / hopelessness
- Worry about cancer
- Odd experiences
- Memory / concentration
- Self-esteem / confidence

(2nd) Most Pressing

Physical Concerns

- Breathing
- Eating / weight
- Toileting
- Fatigue/Exhaustion
- Sleep problems
- Nausea
- Headaches
- Pain

(3rd) Most Pressing

4. ACTION TAKEN FOR EACH CONCERN

- No action
- Declined Help
- Help Given
- Referral
- Other (state)

- No action
- Declined Help
- Help Given
- Referral
- Other (state)

- No action
- Declined Help
- Help Given
- Referral
- Other (state)

Clinician Name _____ Designation _____ Specialty _____ Date _____

Outcome/Referred to (describe) _____ Please file with additional information in notes & return the feedback form

LNR Psychological & Emotional Quick Screen Feedback Form v7 (Nov08)

INSTRUCTIONS

We would be grateful if you can fill in this form after **each application (for each patient)** of the Psychological Support Services Quick Screen, so that we can evaluate its success. Please return a copy for all patients not just those with high scores. This form can be completed by any relevant clinical nurse specialist. Please fax to the address below (for queries ring 0116 2256218).

PATIENT RESULTS

Where is the patient on the patient pathway? Diagnosis In-Treatment Remission Recurrence/Late Other

How many times have you seen this person ? First time Second time Third time Four or Five Many

What was the score on the Distress Thermometer? _____ Change: Deteriorating Improving Stable

What were the three most pressing concerns? (1)_____ (2)_____ (3)_____ OR None

What was your clinical impression **BEFORE** screening? (tick any that apply)

Distressed Depressed Anxious Angry Unsure Well Other _____

What was your clinical impression **AFTER** screening?

Distressed Depressed Anxious Angry Unsure Well Other _____

ACTION TAKEN FOR EACH CONCERN

(1)	(2)	(3)	(4) N/A
<input type="checkbox"/> No action	<input type="checkbox"/> No action	<input type="checkbox"/> No action	
<input type="checkbox"/> Declined Help	<input type="checkbox"/> Declined Help	<input type="checkbox"/> Declined Help	<input type="checkbox"/> There were no concerns
<input type="checkbox"/> Help Given	<input type="checkbox"/> Help Given	<input type="checkbox"/> Help Given	
<input type="checkbox"/> Referral	<input type="checkbox"/> Referral	<input type="checkbox"/> Referral	
<input type="checkbox"/> Other (state)	<input type="checkbox"/> Other (state)	<input type="checkbox"/> Other (state)	

YOUR FEEDBACK

Training **Did the training you received help with detection of emotional problems?**
 Yes No Don't Know Did not receive training

Practicality **Is the enclosed screening instrument practical for your setting?**
 Yes No (too long) No (other reason) _____

Discussion **Did the instrument help you talk about psychosocial issues with the patient?**
 Yes No Don't Know

Detection **Did the instrument help you detect psychological problems such as depression / anxiety**
 Yes No Don't Know

Confidence **How would you rate your usual confidence in detecting emotional problems**
 High Above Av. Average Below Av. Low

COMMENTS **Do you have any specific comments or suggestions for us (please write in the space below)?**

Clinician Name _____ Specialty _____ Date _____

Designation _____ Return a FAXED copy to Alex Mitchell, Liaison Psychiatry, LGH **0116 2951951**