

Remote Symptom Practice Guides
for
Adults on Cancer Treatments

Of the Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Team

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These COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments are intended for use by trained nurses. They provide general guidance on appropriate practice based on a synthesis of clinical practice guidelines and their use is subject to the nurses' judgment in each individual case. Given the unique needs of patients undergoing bone marrow transplant, these clinical practice guidelines were not included. The COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments are designed to provide information to assist decision-making and are not meant to be prescriptive. Individuals who use these practice guides are required to make their own determination regarding specific safe and appropriate clinical practices. While care has been taken to ensure that these practice guides 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 the original project make any warranty or guarantee in respect to any of the content or information contained in these practice guides. Neither group accept responsibility or liability whatsoever for any errors or omissions in these practice guides, regardless of whether those errors or omissions were made negligently or otherwise.

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Overview and Practice Guide Development

Management of cancer treatment-related symptoms is an important safety issue given that symptoms can become life-threatening and often occur when patients are at home. Over 50% of cancer nurses in Canada provide remote support (telephone, email).[1,2] Despite that higher quality telephone services require use of symptom practice guides to minimize risk, access to and use is variable.[1,2] With funding from the Canadian Partnership Against Cancer, in 2008 we established a pan-Canadian Steering Committee with representation from eight provinces to develop 13 symptom practice guides.

The practice guides were developed using a systematic process guided by CAN-IMPLEMENT©:[3-5]

1. We convened a pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Steering Committee including researchers, an information systems researcher, library scientist, advanced practice nurses, and nurse leaders.
2. We conducted a systematic review for *each symptom* to identify clinical practice guideline(s) published in the previous 5 years. Two identified guidelines (fatigue, anxiety/depression) were developed by pan-Canadian panels using rigorous processes.[6,7] Guidelines are syntheses of the best available evidence and are designed to support decision making in practice and health policy.[8] However, identified clinical practice guidelines were not adequate for remote symptom support.
3. We developed 13 symptom practice guides based on the available clinical practice guidelines (median 3 guidelines per practice guide; range 1 to 7). In total, we identified > 40 practice guidelines and their quality was appraised using the AGREE instrument (range 8% to 87%).[9] Higher rigour scores indicate higher confidence that potential biases in guideline development were addressed, and recommendations are valid (both internally and externally) and feasible for practice.[10] Principles for developing the symptom practice guides included:
    - □ Meeting the criteria on the AGREE rigour sub-scale items (e.g. explicit recommendations, linked to evidence, based on systematic review, reviewed by experts).
    - □ Adding relevant questions from the valid and reliable Edmonton Symptom Assessment System (ESAS); a widely used screening instrument for routinely identifying symptoms in cancer patients seen in Canadian programs.[11,12]
    - □ Enhancing usability for remote symptom support and with the potential to integrate into an electronic health record.
    - □ Using plain language to facilitate communication between nurses using the practice guides and patients/families (Flesch–Kincaid Grade Level 6.4).

    Each symptom practice guide has five recommendations for the nurse: a) assess symptom severity; b) triage patient for symptom management based on highest severity; c) review medications being used for the symptom; d) review self-management strategies (presented using motivational interviewing techniques):[13] and e) summarize and document the plan agreed upon with the patient.
4. We tested the practice guide usability with cancer nurses and revealed that they: are easy to read; provide just the right amount of information; use appropriate terms; are likely to fit with clinical work flow; and have excellent self-management strategies.
5. We circulated the 13 practice guides for review by cancer experts across Canada. They validated the content of the practice guides and identified the need for local adaptation to integrate the practice guides with their current approaches for handling remote symptom assessments.
6. In March 2013, practice guides were updated with evidence from a systematic review to identify guidelines published up until the end of December 2012. We circulated the 13 updated practice guides for review by the COSTaRS committee members.
7. In 2013-2015 a CIHR funded study was conducted to evaluate the implementation of the symptom practice guides in three different oncology programs in Ontario, Quebec, and Atlantic Canada.
8. In January 2016, with funding from the Canadian Cancer Society (#703679), the 13 symptom practice guides were updated with evidence from a systematic review to identify guidelines published up to August 2015. As well, new practice guides for pain and sleep problems were added. AGREE Rigour Scores for source guidelines were removed given inconsistent reporting. Evidence ratings were changed to indicate how well the medications work (e.g. effective, likely effective, or expert opinion). The 15 practice guides

were reviewed by the current COSTaRS committee members and a summary of changes for the 2016 update are available at http://www.ktcanada.ohri.ca/costars/.

In summary, we have developed 15 user-friendly remote symptom practice guides based on a synthesis of the best available evidence, validated the practice guides with oncology nurses, and used plain language to facilitate use with patients. Now they are available to be used in routine remote support practices.

References:

(1) Stacey D, Bakker D, Green E, Zanchetta M, Conlon M. Ambulatory oncology nursing telephone services: A provincial survey. *Canadian Oncology Nursing Journal* 2007;17(4):1-5.

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(3) Harrison MB, Legare F, Graham ID, Fervers B. Adapting clinical practice guidelines to local context and assessing barriers to their use. *Canadian Medical Association Journal* 2010;182(2):E78-E84.

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(5) Stacey D, Macartney G, Carley M, Harrison MB, COSTaRS. Development and evaluation of evidence-informed clinical nursing protocols for remote assessment, triage and support of cancer treatment-induced symptoms. *Nurs Res Pract* 2013;2013:171872.

(6) Howell D, Currie S, Mayo S et al. A Pan-Canadian Clinical Practice Guideline: Assessment of Psychosocial Health Care Needs of the Adult Cancer Patient. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology; 2009.

(7) Howell D, Keller-Olaman S, Oliver TK et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Cancer-Related Fatigue in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology; 2011.

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(11) Barbera L, Seow H, Howell D et al. Symptom burden and performance status in a population-based cohort of ambulatory cancer patients. *Cancer* 2010;116(24):5767-5776.

(12) Nekolaichuk C, Watanabe S, Beaumont C. The Edmonton Symptom Assessment System: a 15-year retrospective review of validation studies (1991-2006). *Palliative Medicine* 2008;22(2):111-122.

(13) Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change (2nd ed.)*. New York: Guilford Press; 2002.

Anxiety Practice Guide

Name
Date of Birth
Sex

Date and Time

Anxiety: an emotional or physiologic response to known or unknown causes that ranges from a normal reaction to extreme dysfunction. It may impact on decision making, adherence to treatment, functioning, or quality of life; nervousness; concern; worry; apprehension.[3]

1. Assess severity of the anxiety (Supporting evidence: 2 guidelines) [2,3]

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

Not anxious 0 1 2 3 4 5 6 7 8 9 10 Worst possible anxiety [1(ESAS)]

Do have any concerns that are making you feel more anxious (e.g. life events, new information about cancer/treatment, financial problems)? ☐Yes ☐No If Yes, describe: _____

_____

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

Patient rating (see ESAS above)[1-3]	1 – 3	☐	4 - 6	☐	7 - 10	☐
Are you having panic attacks; periods/spells of sudden fear, discomfort, intense worry, uneasiness?[2,3] Describe.	No	☐	Yes, some	☐	Yes, often	☐
How much does your anxiety affect your daily activities at home and/or at work?[2,3] Describe.	Not at all	☐	Yes, some	☐	Yes, significantly	☐
How much does your anxiety affect your sleep?[2,3]	Not at all	☐	Yes, some	☐	Yes, significantly	☐
Do any of these apply to you? ☐ Female ☐ Waiting for test results, ☐ Financial problems, ☐ History of anxiety or depression, ☐ Younger age (< 30), ☐ Withdrawal from alcohol/ substance use, ☐ Living alone, ☐ Dependent children ☐ Recurrent/advanced disease, ☐ Not exercising, ☐ Recently completed treatment?[2,3]	No	☐	Some	☐	Several	☐
Are you feeling (symptom-related risk factors for anxiety):[3] ☐ Fatigue, ☐ Short of breath, ☐ Pain, ☐ Sleep problems, ☐ Other If yes, see appropriate symptom practice guide.	None	☐	Some	☐	Several, with ≥1 symptoms assessed as severe	☐
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others?[2,3]	No	☐			Yes	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 2 guidelines)**[2,3]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If potential for harm, refer for further evaluation immediately. ☐ If no, refer for non-urgent medical attention. ☐ Review self-care. ☐ Verify medication use, if appropriate.	

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

Additional Comments:

Patient Name_____

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

Current use	Examples of medications for anxiety*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®)[2,3]		Expert opinion
☐	SSRIs - fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), fluvoxamine (Luvox®), escitalopram (Lexapro®)[2,3]		Expert opinion

*****Use of medications should be based on severity of anxiety and potential for interaction with other medications.[2]

4. Review self-care strategies **(Supporting evidence: 2 guidelines)**[2,3]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing when you feel anxious?
2. ☐	☐	☐	What helps when you feel anxious? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Would more information about your cancer or your treatment help to ease your worries? If yes, provide appropriate information or suggest resources.[2,3]
4. ☐	☐	☐	Would more information about your symptoms help to ease your worries? If yes, provide appropriate information or suggest resources.[2,3]
5. ☐	☐	☐	Have you shared your concerns and worries with your health provider?[3]
6. ☐	☐	☐	What are you doing for physical activity including yoga?[2,3]
7. ☐	☐	☐	Do you participate in any support groups and/or have family/friends you can rely on for support? [2,3]
8. ☐	☐	☐	Have you tried relaxation therapy, breathing techniques, listening to music, guided imagery? [2,3]
9. ☐	☐	☐	Have you tried massage therapy with or without aromatherapy?[3]
10. ☐	☐	☐	Have you tried a program such as cognitive-behavioural therapy, mindfulness-based stress reduction, or received personal counseling that provides more in-depth guidance on managing anxiety and problem solving?[2,3]

5. Summarize and document plan agreed upon with caller including ongoing monitoring

(check all that apply)

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Bruera E, et al. (1991); 2. Howell D, et al. (2015); 3. ONS-PEP Anxiety (2015). (See pages 36-39 for complete references).

Appetite Loss Practice Guide

Name
Date of Birth
Sex

Date and Time

Anorexia: An involuntary loss of appetite[1,3]; being without hunger.

1. Assess severity of the appetite loss **(Supporting evidence: 2 guidelines)**[2,3]

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 [4(ESAS)]

How worried are you about your poor appetite?[3]

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)[2-4]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about poor appetite (see above)[3]	0-5	☐	6-10	☐		
How much have you had to eat and drink in past 24 hours (e.g. at each meal)?[3] (compared to your normal food intake)	Some	☐	Minimal	☐	None	☐
Is there anything causing your lack of appetite:[3] ☐ Recent surgery or treatment ☐ New medication ☐ Other symptoms, describe.	No	☐	Yes, some	☐	Yes, several	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[3]	No	☐	Yes, some	☐	Yes, significantly	☐
Does your poor appetite interfere with your daily activities at home and/or at work?[3] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Have you lost weight in the last 4 weeks without trying?[3] Amount: ☐Unsure	0-2.9%	☐	3-9.9%	☐	≥10%	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)**[3]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If severe loss of appetite is stabilized, review self-care strategies ☐ If severe loss of appetite is new refer for medical attention immediately.	

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

Additional comments:

Patient Name_____

3. Review medications patient is using for appetite loss, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 2 guidelines)**[1,2]

Current use	Examples of medications for appetite	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	megestrol (Megace®)[1,2]		Effective
☐	Corticosteroids* - dexamethasone (Decadron®), prednisone[1]		Effective

* Corticosteroids offer short-lived benefit. Long-term use is associated with significant toxicities. Cannabis/Cannabinoids are not recommended.[1]

4. Review self-care strategies **(Supporting evidence: 3 guidelines)**[1-3]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for improving your appetite?
2. ☐	☐	☐	What helps when you feel like you are not hungry? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Are you trying to eat 5-6 small meals?[3]
4. ☐	☐	☐	Are you trying to eat more when you feel most hungry?[3]
5. ☐	☐	☐	Are you trying to eat foods that are higher in protein and calories such as cheese, yogurt, eggs, or milk shakes?[3]
6. ☐	☐	☐	Are you able to obtain groceries and help prepare your meals (access to food, financial resources)? If preparing meals is a problem ask friends family to help or buy convenience foods.[3]
7. ☐	☐	☐	Are you drinking any higher energy and protein drinks (Ensure, Glucerna, Boost®)?[1,3]
8. ☐	☐	☐	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week)[2]
9. ☐	☐	☐	Have you spoken with a dietitian?[1-3]
10. ☐	☐	☐	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)**

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. ONS-PEP Anorexia (2015); 2. Dy SM, et al. (2008); 3. Cancer Care Ontario (2012); 4. Bruera E, et al. (1991). (See pages 36-39 for complete references).

Bleeding Practice Guide

Bleeding: Loss of blood, bruising or petechiae that may be the result of a reduction in the quantity or functional quality of platelets, an alteration of clotting factors, a paraneoplastic syndrome, or a combination of these;[1] hemorrhage.

Name
Date of Birth
Sex

Date and Time

1. Assess severity of the bleeding (Supporting evidence: 1 guideline)[1]

Where are you bleeding from? _____ How much blood loss? _____

How worried are you about your bleeding?

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

How much are you bleeding?[1]	Minor	☐	Some	☐	Gross	☐
Patient rating of worry about bleeding (see above)	0-5	☐	6-10	☐		
Do you have any bruises?[1]	No	☐	Few	☐	Generalized	☐
Have you had any problems with your blood clotting? ☐Unsure	No	☐			Yes	☐
Do you have a fever > 38º C?[1] ☐Unsure	No	☐			Yes	☐
Do you have any blood: ☐ In your stool or is it black?[1] ☐ In your urine ☐ In your vomit or does it look like coffee grounds?[1] ☐ In your phlegm/sputum when you cough[1] ☐ Other	No	☐			Yes	☐
Women only: Has there been an increase bleeding with your menstrual periods?[1]	No	☐	Yes, some	☐	Yes, significantly	☐
Do you know what your last platelet count was? [1] Date: ☐Unsure	≥ 100	☐	20-99	☐	< 20	☐
Are you taking any medicines that increase the risk of bleeding? (e.g., acetylsaliscylic acid (Aspirin), warfarin (Coumadin), heparin, dalteparin (Fragmin), tinzaparin (Innohep), enoxaparin (Lovenox), apixaban (Eliquis)	No	☐	Yes, acetylsalicylic acid	☐	Yes, other blood thinners	☐
If warfarin, do you know your last INR blood count[1] Date: ☐Unsure						
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)**[1]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional comments:

Patient Name_____

3. Review medications/treatment patient is using for bleeding, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 3 guidelines)**[1-3]

Current use	Examples of medications for bleeding	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Platelet transfusion for thrombocytopenia[1,3]		Effective
☐	Mesna oral or IV to prevent cystitis with bleeding[1,2]		Effective

4. Review self-care strategies **(Supporting evidence: 1 guideline)**[1]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing the bleeding?
2. ☐	☐	☐	Are you trying to apply direct pressure for 10-15 minutes when the bleeding occurs?[1]
3. ☐	☐	☐	Are you trying to use ice packs?[1]
4. ☐	☐	☐	If you have a dressing, is there bleeding when it is changed? If yes, do you try to minimize how often the dressing is done, and use saline to help remove the dressing so it does not stick to the tissue?[1]
5. ☐	☐	☐	Are you using any special dressings to control bleeding of a wound (e.g. non-stick gauze, medicated dressing, packing)?[1]
6. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.[1]
7. ☐	☐	☐	Have you spoken with a pharmacist or doctor about medications you are taking that may affect bleeding?

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. ONS-PEP Prevention of Bleeding (2015); 2. Hensley ML, et al. (2009); 3. Estcourt L, et al. (2012). (See pages 36-39 for complete references).

Breathlessness/Dyspnea Practice Guide

Name
Date of Birth
Sex

Date and Time

Breathlessness/Dyspnea: A subjective experience described as breathing discomfort of varying intensities.[1-4] Includes descriptors such as hard to breathe, feeling smothered, tightness in chest, unable to catch breath, panting, gasping.

1. Assess severity of the breathlessness (Supporting evidence: 2 guidelines)[2,3]

Tell me what number from 0 to 10 best describes your shortness of breath?

No shortness of breath 0 1 2 3 4 5 6 7 8 9 10 Worst possible shortness of breath [5(ESAS)]

How worried are you about your shortness of breath?

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)[3,5]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about shortness of breath (see above)[2]	0-5	☐	6-10	☐		
With what level of activity do you experience this shortness of breath?	Moderate activity	☐	Mild activity	☐	At rest	☐
Do you pause while talking every 5-15 seconds?[3]	No	☐			Yes	☐
Do you have pain in your chest when you breathe?[3]	No	☐			Yes	☐
Is your breathing noisy, rattily or congested?[3]	No	☐			Yes	☐
Did you wake suddenly with shortness of breath?[3]	No	☐			Yes	☐
Do you have a fever > 38º C?[3] ☐Unsure	No	☐			Yes, with breathlessness	☐
Does your shortness of breath interfere with your daily activities at home and/or at work? Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)[3]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional comments:

Patient Name_____

3. Review medications patient is using for shortness of breath, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 3 guidelines)**[1-3]

Current use	Examples of medications for shortness of breath*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Oxygen[1,2]		Expert Opinion
☐	Immediate-release oral or parenteral opioids - morphine (Statex®), hydromorphone (Dilaudid®), fentanyl[1,2,3]		Effective

* Palliative oxygen is not recommended.[1]

4. Review self-care strategies **(Supporting evidence: 3 guidelines)**[1,3,4]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing when you feel short of breath?
2. ☐	☐	☐	What helps when you are short of breath? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Have you tried to use a fan or open window to increase air circulation directed at your face?[1]
4. ☐	☐	☐	Have you tried to turn down the temperature in your house?[1,3]
5. ☐	☐	☐	Are you trying to rest in upright positions that can help you breath?[1,3]
6. ☐	☐	☐	Are you trying different relaxation and breathing exercises (e.g. diaphragmatic breathing, pursed lip breathing)?[1,3,4]
7. ☐	☐	☐	If you have a wheelchair, portable oxygen or walking aids, are you trying to use them to help with activities that cause your shortness of breath?[1,4]
8. ☐	☐	☐	If you have difficulty eating, are you taking nutrition supplements[1]
9. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. [1,3]
10. ☐	☐	☐	Have you tried a program such as cognitive behavioural therapy (relaxation therapy, guided imagery) to help manage your shortness of breath?[1,3](Can decrease anticipatory worry associated with exertional dyspnea)

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. ONS-PEP Dyspnea (2014); 2. Dy SM, et al. (2008); 3. Cancer Care Ontario (2010); 4. Bausewein C, et al. (2008); 5. Bruera E, et al. (1991). (See pages 36-39 for complete references).

Constipation Practice Guide

Name
Date of Birth
Sex

Date and Time

Constipation: A decrease in the passage of formed stool characterized by stools that are hard and difficult to pass.[1,2]

1. Assess severity of the constipation (Supporting evidence: 2 guidelines)[1,2]

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 [3(ESAS)]

How worried are you about your constipation?[2]

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)[3]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about constipation (see above) [2]	0-5	☐	6-10	☐		
How many days has it been since you had a bowel movement (compared to your normal pattern)?[1,2]	≤ 2 days	☐	3 days or more	☐	3 days or more on meds	☐
How would you describe your stools (colour, hardness, odour, amount, blood, straining)?[2]					Bleeding (gross)	☐
Do you have any pain in your abdomen?[2] Describe.	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Does your abdomen feel bloated?[2,4] ☐Unsure	No	☐	Yes, some	☐	Yes, a lot	☐
Do you have lots of gas?[2,4]	No	☐	Yes	☐		
Do you feel like your rectum is not emptying after a bowel movement or do you have hemorrhoids?[2,4]	No	☐	Yes	☐		
Are you taking any medications that cause constipation?[2]	No	☐	Yes	☐		
Have you recently had abdominal surgery?[1]	No	☐			Yes	☐
Do you have any other symptoms? ☐ Nausea/vomiting[1,2] ☐ Loss of appetite[1,2] ☐ Urinary symptoms such as leaking urine, or feeling like you cannot empty your bladder[2]	No	☐	Yes, some	☐	Yes, often	☐
Does your constipation interfere with your daily activities at home and/or at work? [2,4] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: expert opinion)**	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional comments:

Patient Name_____

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

Current use	Examples of medications for constipation*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Oral sennosides (Senokot®)[1,2]		Likely effective
☐	Bisacodyl (Dulcolax®)[1,2] and/or lactulose[1,2]		Expert Opinion
☐	Suppositories** (Dulcolax®/bisacodyl, glycerin)[1,2] or Enema[2]		Expert Opinion
☐	Picosulfate sodium-magnesium oxide-citric acid[2]		Expert Opinion
☐	Polyethylene glycol (PEG; RestoaLAX®, Lax-a-day®) [1,2]		Likely effective
☐	Methylnaltrexone injection for opioid as cause[1]		Effective
☐	Docusate sodium (Colace®)[1,2]		Likely effective

*Opioid-induced constipation must be considered. Fentanyl and oxycodone+naloxione have less constipation[1]. ** Verify blood count before using suppositories.

4. Review self-care strategies **(Supporting evidence: 2 guidelines)**[1,2]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing your constipation?
2. ☐	☐	☐	What helps when you are constipated? Reinforce as appropriate.[2] Specify:
3. ☐	☐	☐	What is your normal bowel routine? Reinforce as appropriate.[1,2] Specify:
4. ☐	☐	☐	Are you trying to drink fluids, 6-8 glasses per day, especially warm or hot fluids?[1,2]
5. ☐	☐	☐	Have you increased the fiber in your diet to 25g/day?(Only appropriate if adequate fluid intake (1500ml/24 hrs.) and physical activity)[1,2]
6. ☐	☐	☐	Do you eat fruit that are laxatives? (pitted dates, prune nectar, figs, pitted prunes)[2]
7. ☐	☐	☐	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week)[2]
8. ☐	☐	☐	Do you have easy access to a private toilet or bedside commode,[1,2] with necessary assistive devices (raised toilet seat)? If possible, it is best to avoid a bedpan.[1]
9. ☐	☐	☐	Are you avoiding non-sterilized corn syrup and castor oil?[1] (Corn syrup can be a source of infection; castor oil can cause severe cramping)
10. ☐	☐	☐	If you have a low neutrophil count are you trying to avoid rectal exams, suppositories, enemas?[1]
11. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
12. ☐	☐	☐	Have you spoken with a doctor or pharmacist or dietitian about the constipation?[1,2]

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. ONS-PEP Constipation (2015); 2. Cancer Care Ontario (2012); 3. Bruera E, et al. (1991); 4. NIH-NCI (2010). (See pages 36-39 for complete references).

Depression Practice Guide

Name
Date of Birth
Sex

Date and Time

Depression: a range of feelings and emotions from normal sadness to chronic, depressed emotional affect, feelings of despair, irritable mood, hopelessness.[3]

1. Assess severity of the depression **(Supporting evidence: 2 guidelines)**[2,3]

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 [1(ESAS)]

Do you have any concerns that are making you feel more depressed (e.g. life events, new information about cancer/treatment, financial problems) ☐Yes ☐No Specify: _____

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

Patient rating (see ESAS above)[1-3]	1-3	☐	4-6	☐	7-10	☐
Have you felt depressed or had a loss of pleasure for 2 weeks or longer?[2,3]	No	☐	Yes, off/on	☐	Yes, continuous	☐
Have you experienced any of the following for ≥ 2 weeks: ☐ feeling worthless, ☐ sleeping too little or too much, ☐ feeling guilty, ☐ weight gain or weight loss ☐ unable to think or concentrate?[2,3]	No	☐	Yes, some	☐	Yes, several	☐
Does feeling depressed interfere with your daily activities at home and/or at work?[2] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Have you felt tired or fatigued?[2,3] Describe.	No	☐	Yes, moderate	☐	Yes, often	☐
Have you felt agitated (which may include twitching or pacing) or slowing down of your thoughts?[2,3]	No	☐	Yes, some	☐	Yes, often	☐
Do any of these apply to you? ☐ younger age (< 30), ☐female ☐ bothersome symptoms, ☐ a lack of social support, ☐ history of depression ☐ financial problems, ☐ withdrawal from alcohol/substance abuse, ☐ living alone, ☐ dependent children, ☐ recurrent/advanced disease ☐ recently completed treatment,?[2]	None	☐	Yes, some	☐	Yes, several	☐
Are you feeling (symptom-related risk factors for depression):[3] ☐ Fatigue, ☐ Pain, ☐ Sleep problems, ☐ Other If yes, see appropriate symptom practice guide.	None	☐	Some	☐	Several, with ≥ 1 symptoms assessed as severe	☐
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others?[2,3]	No	☐			Yes	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)[2,3]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If potential for harm, refer for further evaluation immediately. ☐ If no, refer for non-urgent medical attention. ☐ Review self-care. ☐ Verify medication use, if appropriate.	

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

Additional Comments:

Patient Name_____

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

Current use	Examples of medications for depression*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	SSRIs - fluoxetine (Prozac®), sertraline (Zoloft®), paroxetine (Paxil®), citalopram (Celexa®), fluvoxamine (Luvox®), escitalopram (Lexapro®)[2,3]		Effective
☐	Tricyclic antidepressants - amitriptyline (Elavil®), imipramine (Tofranil®), desipramine (Norpramin®), nortriptyline (Pamelor®), doxepin (Sinequan®)[3]		Effective

*****Antidepressant medication is effective for major depression but use depends on side effect profiles of medications and the potential for interaction with other medications.

4. Review self-management strategies **(Supporting evidence: 2 guidelines)**[2,3]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for feeling less depressed?
2. ☐	☐	☐	What helps when you feel depressed? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Would more information about your cancer or your treatment help to ease your worries? If yes, provide appropriate information or suggest resources.[2,3]
4. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.[2,3]
5. ☐	☐	☐	What are you doing for physical activity?[2,3]
6. ☐	☐	☐	Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)?[2]
7. ☐	☐	☐	Do you participate in any support groups and/or have family/friends you can rely on for support? [2,3]
8. ☐	☐	☐	Have you tried relaxation therapy or guided imagery?[2,3]
9. ☐	☐	☐	Have you tried a program such as cognitive-behavioural therapy, mindfulness-based stress reduction or received personal or couple counseling that provides more in-depth guidance on managing depression?[2,3]

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Bruera E, et al. (1991); 2. Howell D, et al. (2015); 3. ONS-PEP Depression (2015). (See pages 36-39 for complete references).

Diarrhea Practice Guide

Name
Date of Birth
Sex

Date and Time

Diarrhea: An abnormal increase in stool liquidity and frequency over baseline (> 4-6 stools/day) which may be accompanied by abdominal cramping.[4,6,7]

1. Assess severity of the diarrhea (Supporting evidence: 7 guidelines)[1-7]

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 [9(ESAS)]

How worried are you about your diarrhea?[7]

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)[9]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about diarrhea (see above)[5,7]	0-5	☐	6-10	☐		
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?[1-8]	< 4 stools	☐	4-6 stools	☐	≥ 7 stools	☐
How would you describe your stools (colour, hardness, odour, amount, oily, blood, straining)? [3,5,6,7]					Bleeding (gross)	☐
Ostomy: How much extra output are you having, above what is normal for you?[3-6,8] ☐ N/A	Mild increase	☐	Moderate increase	☐	Severe increase	☐
Do you have a fever > 38º C?[3-7] ☐Unsure	No	☐			Yes, with diarrhea	☐
Do you have pain in your abdomen or rectum with or without cramping or bloating?[3,5-7]	No	☐	Yes, some	☐	Yes, often	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[3-7]	No	☐	Yes, some	☐	Yes, significantly	☐
Have you been able to drink fluids?[5,6]	Yes	☐			No	☐
Does your diarrhea interfere with your daily activities at home and/or at work?[3,6-8] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Do you have any other symptoms? ☐ Nausea/vomiting[3,4,6,7] ☐ Loss of appetite[7]	No	☐	Yes, some	☐	Yes, often	☐
Are you taking any medicines that increase the risk of diarrhea? (e.g., oral sennosides (Senokot®), Docusate sodium (Colace®))?	No	☐	Yes			
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 7 guidelines)[1-7]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional Comments:

Patient Name_____

3. Review medications patient is using for diarrhea, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 8 guidelines)[1-6,10,11]

Current use	Examples of medications for diarrhea*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Loperamide (Imodium®)[1-6,10,11]		Likely effective
☐	Octreotide (Sandostatin®)[1-6,10,11]		Likely effective
☐	Psyllium fibre for radiation-induced (Metamucil®)[4,11]		Likely effective
☐	Atropine-diphenoxylate (Lomotil®)[4-6]		Expert opinion

* Sucralfate is not recommended for radiation-induced diarrhea.[4]

4. Review self-care strategies (Supporting evidence: 7 guidelines)[3-7, 10,11]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing diarrhea?
2. ☐	☐	☐	What helps when you have diarrhea?[5] Reinforce as appropriate. Specify:
3. ☐	☐	☐	Are you trying to drink 8-10 glasses clear fluids per day (e.g. water, sports drinks, broth, diluted fruit juice)?[3-7,11]
4. ☐	☐	☐	Do you know what kinds of foods you should be trying to eat? Suggest: applesauce, oatmeal, bananas, barley, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned turkey or chicken, mashed potatoes, cooked or canned fruit without skin[3-7] (high in soluble fiber and low in insoluble fiber)
5. ☐	☐	☐	Are you trying to replace electrolytes (e.g. potassium and sodium or salt) that your body may be losing with the diarrhea by eating foods such as bananas and potatoes, drinking sports drinks or peach/apricot nectar, or oral rehydration drink (1/2 tsp. salt, 6 tsp. sugar, 4 cups water)?[4,7,11]
6. ☐	☐	☐	Are you trying to eat 5-6 small meals?[3,5-7]
7. ☐	☐	☐	Do you know what to avoid? Suggest: greasy/fried and spicy foods, alcohol and minimize caffeine (<2-3 servings) (coffee, chocolate)[3-7] large amounts fruit juices or sweetened fruit drinks[3,4,7] raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes[4,6,7] (Insoluble fiber), very hot or very cold, sorbitol in sugar-free candy, lactose-containing products (milk, yoghurt, cheese)[3,4,6,7]
8. ☐	☐	☐	Are you trying to keep skin around your rectum or ostomy clean to avoid skin breakdown? [5,6,7]
9. ☐	☐	☐	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)[3,6] (review criteria listed above in assessment)
10. ☐	☐	☐	Were you taking probiotics with lactobacillus to prevent diarrhea?[10]
11. ☐	☐	☐	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.
12. ☐	☐	☐	Have you spoken with a doctor or pharmacist about medications you may be taking that can cause or worsen your diarrhea?[6]

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Major P, et al. (2004); 2. Keefe DM, et al. (2007); 3. Benson AB, III, et al. (2004); 4. ONS-PEP Diarrhea (2015); 5. BC Cancer Agency (2004); 6. Schwartz L, et al. (2014); 7. Cancer Care Ontario (2012); 8. NIH-NCI (2010); 9.Bruera E, et al. (1991); 10. Lalla RV, et al. (2014); 11. Vehreschild MJ, et al. (2013). (See pages 36-39 for complete references).

Fatigue/Tiredness Practice Guide

Name
Date of Birth
Sex

Date and Time

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.[1]

1. Assess severity of the fatigue/tiredness (Supporting evidence: 2 guidelines)[1,2]

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 [3(ESAS)]

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)[1,3]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about fatigue (see above)	0-5	☐	6-10	☐		
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? [1]	No	☐			Yes	☐
How would you describe the pattern of fatigue?[1]	Intermittent	☐	Constant/ Less than two weeks	☐	Constant/ Daily for two weeks	☐
Does your fatigue interfere with your daily activities at home and/or at work?[1] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Are there times when you feel exhausted? Describe.	No	☐	Yes, intermittently	☐	Yes, constantly for two weeks	☐
Do you have any treatment side effects such as low red blood cells, infection, fever?[1]	No	☐			Yes	☐
Do you have any other symptoms? Anxiety, appetite loss, poor intake of fluids, feeling depressed, pain, sleep problems[1]	No	☐	Yes, some	☐	Yes, often	☐
Do you drink alcohol? [1]	No	☐	Yes	☐		
Do you have other health conditions that cause fatigue (cardiac, breathing, liver changes, kidney)?[1]	No	☐	Yes	☐		
Are you taking any medicines that increase fatigue? (e.g., medicine for pain, depression, nausea/vomiting, allergies)[2]	No	☐	Yes	☐		
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)[1,2]	☐ Review self-care.		☐ Review self-care. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ If severe fatigue is stable, review self-care strategies ☐ If severe fatigue is new, refer for non-urgent medical attention.	

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

Additional Comments:

Patient Name_____

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

Current use	Examples of medications for fatigue	Notes	Evidence
☐	Ginseng[1,2]		Likely effective but insufficient for some types of ginseng

*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.[1]

4. Review self-care strategies (Supporting evidence: 2 guidelines)[1,2]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing your fatigue?
2. ☐	☐	☐	What helps when you feel fatigued/tired? Reinforce as appropriate.[2] Specify:
3. ☐	☐	☐	Do you understand what cancer-related fatigue is?[2] Provide education about how it differs from normal fatigue, that it is expected with cancer treatment.
4. ☐	☐	☐	Would more information about your symptoms help you to manage them better?[2] If yes, provide appropriate information or suggest resources.
5. ☐	☐	☐	Are you trying to save energy for things that are important to you?[1,2]
6. ☐	☐	☐	What are you doing for physical activity including yoga?[1,2] 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 (i.e. bone metastases)
7. ☐	☐	☐	Do you think you are eating/drinking enough to meet your body's energy needs?[2]
8. ☐	☐	☐	Have you tried activities such as read, games, music, garden, experiences in nature?[2]
9. ☐	☐	☐	Do you participate in any support groups and/or have family/friends you can rely on for support?[1,2]
10. ☐	☐	☐	Have you tried activities to make you more relaxed (e.g. relaxation therapy, deep breathing, guided imagery, or massage therapy)?[2]
11. ☐	☐	☐	Have you done any of the following to improve the quality of your sleep?[1,2] 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. ☐	☐	☐	Have you tried a program such as cognitive behavioural therapy or mindfulness-based stress reduction to manage your fatigue?[1,2]
13. ☐	☐	☐	If need a tailored plan, have you spoken with or would you like to speak with a health care professional to help guide you in managing your fatigue?[1,2] (rehabilitation specialist)

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

☐	No change, continue with self-care strategies
☐	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)?
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Howell D, et al. (2015); 2. ONS-PEP Fatigue (2015); 3. Bruera E, et al. (1991). (See pages 36-39 for complete references).

Febrile Neutropenia Practice Guide

Name
Date of Birth
Sex

Date and Time

Febrile neutropenia: A neutrophil count < 1000 cells/ mm^3 and a single oral temperature of ≥38.3º C (101 ºF) or a temperature of ≥38.0º C (100.4 ºF) for ≥1 hour. [1,2,4,6,7]

1. Assess severity of the fever and neutropenia (Supporting evidence: 9 guidelines)[1-9]

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®) or ibuprofen (Advil®), if yes, how much and when? _____

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

An oral temperature of ≥38.0º C (100.4 ºF)[1-8]	No	☐	Yes	☐
Last known neutrophil count[1-8] _____ Date: ☐Unsure	>1000 cells/mm^3	☐	Fever plus ≤500 cells/mm^3 or 1000 cells/mm^3 with expected drop	☐
	1 **Mild** (Green)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 9 guidelines)[1-9]	☐ Review self-care. ☐ Advise to call back if symptom worsens or new symptoms occur in 12 -24 hours[9]		☐ Refer for medical attention immediately. **Febrile neutropenia treatment with antibiotics should be initiated within 1 hour of presentation.[3,6] Collection of clinical and laboratory data to locate potential site or cause of infection is critical prior to starting antibiotics.[1]**	

Note: For consistency across symptom practice guides a temperature of 38.0º C is used.

Additional Comments:

Patient Name_____

3. Review medications patient is using for preventing febrile neutropenia or decreasing fever, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 1 guideline)**[10]

Current use	Examples of medications	Notes	Evidence
☐	G(M)-CSF[10]		Effective
☐	Antibiotics to prevent infection[10]		Mixed recommendations

*Use of over the counter medications to lower fever in cancer patients (e.g., acetaminophen) is controversial and should not be used to mask a fever of unknown origin.

4. Review self-care strategies to minimize risk of infection **(Supporting evidence: 3 guidelines)**[1,3,4]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			If temperature not ≥38.0º C, are you checking your body temperature with a thermometer? [4]
2. ☐	☐	☐	Are you washing your hands frequently?[1,3]
3. ☐	☐	☐	Are you eating well cooked foods and/or well cleaned uncooked raw fruits and vegetables?[1]
4. ☐	☐	☐	Are you brushing your teeth with a soft toothbrush at least twice a day (dental flossing can be done if it does not cause bleeding)? [1]
5. ☐	☐	☐	Are you taking daily showers or baths? [1]
6. ☐	☐	☐	Are you trying to avoid enemas, suppositories, tampons and invasive procedures? [1]
7. ☐	☐	☐	Are you checking your skin for potential sites of infection (e.g. access devices, rectal area) and keeping these areas clean and dry? [1]
8. ☐	☐	☐	Are you trying to avoid crowds and people who might be sick? [1]
9. ☐	☐	☐	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)**

☐	No change, continue with self-care strategies
☐	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)?
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Freifeld AG, et al. (2011); 2. National Comprehensive Cancer Network (2015); 3. Flowers, C. R., et al. (2013); 4. de Naurois J, et al. (2010); 5. NIH-NCI (2010); 6. Tam CS, et al. (2011); 7. Alberta Health Services (2014); 8. National Institute for Health and Clinical Excellence (2012); 9. Mendes AV, et al. (2007); 10. Neumann S, et al. (2013). (See pages 36-39 for complete references).

Mouth Sores/Stomatitis Practice Guide

Name
Date of Birth
Sex

Date and Time

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.[2,5]

1. Assess severity of the mouth sores **(Supporting evidence: 5 guidelines)**[1-5]

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[6(ESAS)]

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 ESAS above)[4,6]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about mouth sores (see above)[4]	0-5	☐	6-10	☐		
How many sores/ulcers/blisters do you have?[1-4]	0-4	☐	>4	☐	Coalescing/ Merging/Joining	☐
Do the sores in your mouth bleed?[2-4]	No	☐	Yes, with eating or oral hygiene	☐	Yes, spontaneously	☐
Are the sores painful?[1-5]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you see any redness or white patchy areas (isolated or clustered) in your mouth?[1,2,4,5]	No	☐	Yes, some	☐	Yes, often	☐
Do you have a dry mouth?[4]	No	☐	Yes	☐		
Are you able to eat and drink?[2-5] If no, can you open and close your mouth?[4]	Yes	☐			No	☐
Have you lost weight in the last 1-2 weeks without trying?[4] Amount: ☐Unsure	No	☐	Yes	☐		
Are you having trouble breathing?[4]	No	☐	Yes, some	☐	Yes, significantly	☐
Does your mouth sore(s) interfere with your daily activities at home and/or at work?[4] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 4 guidelines)** [1,2,4,5]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional Comments:

Patient Name_____

3. Review medications patient is using for mouth sores, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 5 guidelines)** [2,4,5,7,8]

Current use	Examples of medications for mouth sores	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	benzydamine hydrogen chloride (Tantum mouth rinse)[2]		Likely effective
☐	Oral medications for pain[4,5,8]		Expert opinion
☐	0.5% Doxepin mouth rinse[7]		Expert opinion

* Chlorhexidine mouth rinse and sulcrate are not recommended for treatment.[2]

4. Review self-care strategies **(Supporting evidence: 6 guidelines)**[1,2,4,5,7,8]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing your mouth sores?
2. ☐	☐	☐	What helps when you have mouth sores? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Are you trying to rinse your mouth 4 times a day with a bland rinse (or more often if mouth sores)?[2,5,7] For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish 15 ml (1 tablespoon) in your mouth for at least 30 seconds and spit out.[1,2,4] Prepare daily at room temperature.
4. ☐	☐	☐	Are you trying to brush your teeth at least twice a day using a soft toothbrush and flossing daily or as tolerated (use soft foam toothette in salt/soda water if sores)?[1,2,4,5]
5. ☐	☐	☐	Do you rinse your toothbrush in hot water before using and allow to air dry before storing?[2,4,5]
6. ☐	☐	☐	If you wear dentures and your mouth is sensitive, do you try to use your dentures only at mealtimes?[4,5]
7. ☐	☐	☐	Are you using water-based moisturizers to protect your lips? [1,2,4,5]
8. ☐	☐	☐	Are you sucking on lactobacillus lozenges[2] or zinc lozenges to prevent mouth sores? Xylitol lozenges or chewing on xylitol gum (max. 6 grams per day) for dry mouth?[4]
9. ☐	☐	☐	Are you trying to avoid tobacco and alcohol, including alcohol-based mouthwashes?[2,4,5]
10. ☐	☐	☐	Are you trying to drink 8-10 glasses of fluids per day?[4,5]
11. ☐	☐	☐	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[2,5]
12. ☐	☐	☐	Are you trying to avoid foods and drinks that are acidic, salty, spicy, or very hot or very cold (temperature)?[2,5]
13. ☐	☐	☐	During chemotherapy, are you taking ice water, ice chips or ice lollipops for 30 minutes?[2,7]
14. ☐	☐	☐	For mouth sores, have you considered referral for low level laser therapy?[2,7,8]
15. ☐	☐	☐	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)**

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Keefe DM, et al. (2007); 2. ONS-PEP Mucositis (2014); 3. Quinn B, et al. (2008); 4. Cancer Care Ontario (2012); 5. Broadfield L, et al. (2006); 6. Bruera E, et al. (1991); 7. Lalla RV, et al. (2014); 8. Clarkson JE, et al. (2010). (See pages 36-39 for complete references).

Nausea & Vomiting Practice Guide

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.)[6,10]

Name
Date of Birth
Sex

Date and Time

1. Assess severity of nausea/vomiting (Supporting evidence: 4 guidelines)[1,6,7,10]

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 [8(ESAS)]

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 [8(ESAS)]

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)[1,6,8]	1-3	☐	4-10	☐		
Patient rating for vomiting (see ESAS above) [1,6,8]	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about nausea/vomiting (see above)[6]	0-5	☐	6-10	☐		
How many times per day are you vomiting or retching?[1,6,7,10] ☐No vomiting	≤ 1	☐	2-5	☐	≥6	☐
Have you been able to eat within last 24 hours?[6,7,10]	Yes	☐	No	☐		
Have you been able to tolerate drinking fluids? [6,7,10]	Yes	☐			No	☐
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, fainting, rapid heart rate, decreased amount of urine?[6,10]	No	☐	Yes, some	☐	Yes, significantly	☐
Do you have any blood in your vomit or does it look like coffee grounds?[6] ☐No vomiting	No	☐			Yes	☐
Do you have any abdominal pain or headache?[6]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Does your nausea/vomiting interfere with your daily activities at home and/or at work?[6] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
Do you have any other symptoms? ☐ Constipation ☐ Pain	No	☐	Yes, some	☐	Yes, often	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)[6,7]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional Comments:

Patient Name_____

3. Review medications patient is using for nausea/vomiting, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 8 guidelines)**[1-5,9-11]

Current use	Examples of medications for nausea/vomiting	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	$5HT_3$: ondansetron (Zofran®), granisetron (Kytril®), dolasetron (Anszemet®)[1-5,9,10]		Effective
☐	dexamethasone (Decadron®)[1,2,3,5,9,10]		Likely effective
☐	fosaprepitant, aprepitant (Emend®)[1-5]		Effective
☐	metoclopramide (Maxeran®)[1-5,9,10] prochlorperazine (Stemetil®)[1,2,5,9,10]		Expert opinion
☐	Triple drug: dexamethasone, 5 HT_3 (palonosetron), neurokinin 1 receptor antagonist (Akynzeo)[2,5,11]		Effective
☐	Cannabis (Nabilone, medical marijuana), dronabinol[2,5]		Effective
☐	Gabapentin[5]		Likely effective
☐	Other: lorazepam (Ativan®)[1-3,5,9,10], haloperidol (Haldol®)[2,5]		Expert opinion

*Metopimazine is not recommended for practice.[5]

4. Review self-care strategies **(Supporting evidence: 6 guidelines)** [2-5,6,10]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing your nausea and vomiting?
2. ☐	☐	☐	What helps when you have nausea/vomiting? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Are you trying to drink clear fluids (e.g. water, sports drinks, broth, gingerale, chamomile tea)?[6,10]
4. ☐	☐	☐	Have you tried relaxation techniques that may include guided imagery, music therapy, progressive muscle relaxation, and/or hypnosis?[2,3,5,6,10]
5. ☐	☐	☐	Are you taking anti-emetic medications before meals so they are effective during/after meals?[5,6]
6. ☐	☐	☐	If vomiting, are you limiting food and drink until vomiting stops? After 30-60 minutes without vomiting, sip clear fluids. When clear fluids stay down, add dry starchy foods (e.g. crackers, dry toast, dry cereal, pretzels). If starchy food stay down, add protein rich foods (e.g. eggs, chicken).[6]
7. ☐	☐	☐	Are you trying to: - eat 5-6 small meals or snacks? [2,5,6] - eat foods that minimize your nausea and are your "comfort foods"? [2,5] - avoid greasy/fried, highly salty, and spicy foods? [2,5,6] - eat foods that are cold, avoiding extreme temperatures and strong odors? [2,5,6,10]
8. ☐	☐	☐	Are you sitting upright or reclining with head raised for 30-60 minutes after meals? [6]
9. ☐	☐	☐	Are you wearing loose clothing?[6]
10. ☐	☐	☐	Are you rinsing your mouth before eating and keeping your mouth clean (brushing, rinsing)?[6]
11. ☐	☐	☐	Have you tried acupuncture or acupressure to help with your nausea/vomiting?[4,5,6]
12. ☐	☐	☐	Have you spoken with a dietitian? [10]
13. ☐	☐	☐	Would more information about your symptoms help you to manage them better? [5,6] If yes, provide appropriate information or suggest resources.

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Basch E, et al. (2011); 2. NCCN (2015); 3. Gralla RJ, et al. (2013); 4.Naeim A, et al. (2008); 5. ONS-PEP Chemotherapy-Induced Nausea and Vomiting (2015); 6. Cancer Care Ontario (2010); 7.NIH-NCI (2010); 8.Bruera E, et al. (1991); 9. Feyer PC, et al. (2011); 10. Cancer Care Nova Scotia (2004); 11. Hesketh et al. (2015). (See pages 36-39 for complete references).

Pain Practice Guide

Name
Date of Birth
Sex

Date and Time

Pain: subjective sensory or emotional discomfort associated with actual or potential tissue damage or described in terms of such damage.[2-5]
Types of pain: a) Somatic pain in skin, muscle and bone described as aching, stabbing, throbbing, and/or pressure;[2,4,6] b) Visceral pain in organs or viscera described as gnawing, cramping, aching, or sharp;[4] c) Neuropathic pain from nerve damage described as burning, tingling, shooting, or pins/needles.[4]

1. Assess the pain and severity (Supporting evidence: 7 guidelines)[2,4-9]

1.1 Tell me about the pain (location, onset, type, duration, radiating)

1.2 Tell me what number from 0 to 10 best describes current pain you have (at worst location)?

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain (ESAS)1

1.3 How worried are you about your pain?

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 of current pain (see above)	0 – 3	☐	4 – 6	☐	7 - 10	☐
Patient rating of worst pain (see above)	0 - 3	☐	4 – 6	☐	7 - 10	☐
Patient rating of pain at best	0 - 3	☐	4 – 6	☐	7 - 10	☐
Patient rating of worry about pain (see above)	0 - 5	☐	6 – 10	☐		☐
Was the pain onset sudden?	No	☐	Yes	☐	Yes	☐
Is the pain from a new location?	No	☐	Yes	☐	Yes	☐
How much does pain restrict your daily activities (walking, eating, bathing, sleep)?	None	☐	some	☐	Severe limitations	☐
Does the pain interfere with your mood?	No	☐	Yes	☐		☐
Are you able to get relief of pain from your medications?	Yes, relief	☐	Yes, some	☐	No	☐
How much does the pain medicines restrict your daily activities?	None	☐	some	☐	Severe limitations	☐
Are you feeling other symptoms: constipation, nausea/vomiting, fatigue, itchiness, confusion, new weakness in legs or arms? If yes, see other symptom practice guide(s).	None	☐	Some	☐	Several, with ≥1 symptoms assessed as severe	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 5 guidelines)[2,3,4,6,8]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ Refer for medical attention immediately.	

If patient is experiencing other symptoms, did you also refer to the appropriate practice guides?

Additional Comments:

Patient Name_____

3. Review medications patient is using for pain, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 7 guidelines)[2,4,5,6, 8-10]

Current use	Examples of medications for pain*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Step 1: Non-opioid: acetaminophen, NSAIDs, COX-2 inhibitors		Likely effective
☐	Step 2: Weak opioid: codeine, tramadol		Effective
☐	Step 3: Strong opioid: morphine, oxycodone, fentanyl, hydromorphone		Effective
☐	Breakthrough dose		Effective
☐	Antidepressant or anticonvulsant (neuropathic pain)		Likely effective
☐	Prophylactic constipation treatment – sennosides, bisocodyl, lactulose, Polyethylene glycol (PEG), ducosate sodium		Likely effective/ expert opinion

*Avoid use of long-acting opioids during severe acute pain. If reduced kidney function, fentanyl, methadone, and oxycodone are safest options.[2]

4. Review self-care strategies (Supporting evidence: 8 guidelines)[2-9]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for pain relief (e.g., target on scale of 0 to 10)?
2. ☐	☐	☐	Do you have a family member or friend helping you manage your pain?
3. ☐	☐	☐	Do you understand the plan for taking routine and breakthrough medicines for pain? If no, then educate about pain and pain management
4. ☐	☐	☐	Do you have any concerns or fears about taking pain medicines? If yes, then explore and educate?
5. ☐	☐	☐	Do you have a pain diary to track your level of pain when taking medicine and change in pain about 1-2 hours after taking medicine?
6. ☐	☐	☐	What helps when you have pain? Reinforce as appropriate.
7. ☐	☐	☐	Have you tried massage with or without aromatherapy?
8. ☐	☐	☐	Are you doing any light exercises (walk, swim, cycle, stretch)?
9. ☐	☐	☐	Have you used any physiotherapy or acupuncture?
10. ☐	☐	☐	Are you using activities to help you cope with the pain such as listening to music, breathing exercises, activities for distraction, relaxation, guided imagery?
11. ☐	☐	☐	If taking opioids, are you using medicines to prevent constipation?
12. ☐	☐	☐	If you have other symptoms, are they under control?

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

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

Name	**Signature**	**Date**

References: 1. Bruera E, et al. (1991); 2. Cancer Care Ontario (2010); 3. BC Cancer Agency (2013); 4. Ministry of Health Malaysia (2010); 5. SIGN (2008); 6. National Comprehensive Cancer Network (2015); 7. The British Pain Society (2015); 8. ESMO (2011); 9. Yamaguchi T, et al. (2013); 10.ONS-PEP Pain (2015). (See pages 36-39 for complete references).

Peripheral Neuropathy Practice Guide

Neuropathy: Described as numbness, tingling, burning, 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.[1-3]

Name
Date of Birth
Sex

Date and Time

1. Assess severity of the neuropathy (Supporting evidence: 3 guidelines)[1-3]

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

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 above)	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about neuropathy (see above)	0-5	☐	6-10	☐		
Do you have pain in your _____ (neuropathy location)?[1-3] Describe on a scale of 0 to 10.	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you have new weakness in your arms or legs?[1,2]	No	☐	Yes, some	☐	Yes, often	☐
Have you noticed problems with your balance or how you walk or climb stairs? If yes, how much?[1,2]	No/Mild	☐	Yes, some	☐	Yes, often	☐
Are you constipated or have difficulty emptying your bladder of urine?[1,2]	No/Mild	☐	Yes, some	☐	Yes, often	☐
Does your neuropathy/numbness/tingling interfere with your daily activities at home and/or at work (e.g. buttoning clothing, writing, holding coffee cup)?[1,2] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)[3]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 1-2 days.		☐ Refer for medical attention immediately.	

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

Additional Comments:

Patient Name_____

3. Review medications patient is using for neuropathy, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 5 guidelines)** [1-5]

Current use	Examples of medications for neuropathy*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Duloxetine[1,5]		Likely effective
☐	Anti-convulsants – gabapentin, pregabalin (Lyrica®)[2,4]		Expert opinion
☐	Tricyclic anti-depressants – amitriptyline, nortriptyline, duloxetine (Cymbalta®), venlafaxine (Effexor®), bupropion (Wellbutrin®, Zyban®)[2-4]		Expert opinion
☐	Opioids – fentanyl, morphine (Statex®), hydromorphone (Dilaudid®), codeine, oxycodone[1-3]		Expert Opinion
☐	Topical – lidocaine patch 5%[2,3]		Expert Opinion

*Note: opioids often combined with anticonvulsants or anti-depressants but increase CNS adverse events requiring careful titration. Carnitine/L-carnitine and human leukemia inhibitory factor are not recommended for practice.[1]

4. Review self-care strategies **(Supporting evidence: 3 guidelines)** [1-3]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal in managing the neuropathy?
2. ☐	☐	☐	What helps with managing your neuropathy? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Do you look at your hands and feet every day for sores/blisters that you may not feel?[1,2]
4. ☐	☐	☐	**If neuropathy in feet:** Do you have footwear that fits you properly?[1,2]
5. ☐	☐	☐	In your home: - are the walkways clear of clutter?[1,2] - do you have a skid-free shower or are you using bath mats in your tub?[1,2] - have you removed throw rugs that may be a tripping hazard?[1,2]
6. ☐	☐	☐	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?[1,2]
7. ☐	☐	☐	**If any neuropathy:** To avoid burns due to decreased sensation: -Have you lowered the water temperature in your hot water heater?[1] -Do you use a bath thermometer to ensure water in shower or tub is < 120ºF/49ºC?[1]
8. ☐	☐	☐	Do you try to dangle your legs before you stand up to avoid feeling dizzy?[1,2]
9. ☐	☐	☐	For constipation, do you try eat a high-fiber diet and drink adequate fluids?[1,2]
10. ☐	☐	☐	Have you tried acupuncture?[2]
11. ☐	☐	☐	Have you spoken with a physiotherapist about: - a walker, cane, or a splint to help with your balance and improve walking?[1,2] - a physical training plan or TENS (transcutaneous electrical nerve stimulation)?[2,3]
12. ☐	☐	☐	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?
13. ☐	☐	☐	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)**

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. ONS-PEP Peripheral Neuropathy (2015); 2. Stubblefield MD, et al. (2009); 3. NCCN (2015); 4. Caraceni A, et al. (2012); 5. Hershman D, et al. (2014). (See pages 36-39 for complete references).

Skin Reaction to Radiation Practice Guide

Name
Date of Birth
Sex

Date and Time

Skin reaction/alteration: A change in the colour, texture or integrity of the skin.[3]

1. Assess severity of the skin reaction to radiation **(Supporting evidence: 3 guidelines)**[1-3]

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

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 above)	1-3	☐	4-6	☐	7-10	☐
Patient rating of worry about skin reaction (see above)	0-5	☐	6-10	☐		
Is your skin red?[1-3]	None	☐	Faint/dull	☐	Tender/bright, necrotic	☐
Is your skin peeling?[1-3]	No/Dry	☐	Patchy, moist	☐	Generalized, moist	☐
Do you have any swelling around the skin reaction area?[1,2]	No	☐	Yes, some	☐	Yes, pitting edema	☐
Do you have pain at the skin reaction area?[2,3]	No/Mild 0-3	☐	Moderate 4-6	☐	Severe 7-10	☐
Do you have any open, draining wounds?[2,3]	No	☐			Yes	☐
Do you have any bleeding[1-3]	No	☐	Yes, some	☐	Yes, gross	☐
Do you have a fever > 38° C?[2] ☐Unsure	No	☐			Yes, with skin reaction	☐
Have you started a new medication?[3]	No	☐			Yes	☐
Does your skin reaction interfere with your daily activities at home and/or at work?[2,3] Describe.	No	☐	Yes, some	☐	Yes, significantly	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 2 guidelines)**[1,2]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		☐ Refer for medical attention immediately.	

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

Additional Comments:

Patient Name_____

3. Review medications patient is using for skin reaction, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 3 guidelines)**[1-3]

Current use	Examples of medications for skin reaction to radiation therapy	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Prevention: Calendula ointment[1,3]		Likely effective
☐	Mild-moderate: Low-dose corticosteroid cream[1-3*]		Expert opinion
☐	Mild-moderate: Lanolin free hydrophilic cream (i.e.: glaxal base or Lubriderm)[1]		Expert opinion
☐	Open areas: Silver Sulfadiazine (Flamazine)[2-3]		Likely effective
☐	Open areas: Dressing changes[2]		Expert opinion

*There is insufficient evidence to support or refute other specific topical agents (i.e., corticosteroids, sucralfate cream, ascorbic acid, chamomile cream, almond ointment, polymer adhesive skin sealant) for the prevention of acute skin reaction. Emerging evidence for proteolytic enzymes for treatment of skin reaction from radiation.[4] Biafine® and aloe vera are not recommended for radiation skin reaction.[3]

4. Review self-management strategies **(Supporting evidence: 4 guidelines)**[1-4]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for managing your skin reaction?
2. ☐	☐	☐	What helps when you have a skin reaction? Reinforce as appropriate. Specify:
3. ☐	☐	☐	Are you trying to take warm showers or immersion in warm baths (not soaking in the tub) using mild non-perfumed soap, and patting dry (no rubbing)?[1-4]
4. ☐	☐	☐	Are you trying to use plain, non-scented, lanolin-free, water-based creams on intact skin only?[1-3]
5. ☐	☐	☐	Are you wearing loose clothes?[2]
6. ☐	☐	☐	Are you trying to avoid using petroleum jelly, alcohol, and perfumed products? [2,3]
7. ☐	☐	☐	Are you using non-metallic deodorant? [2-4]
8. ☐	☐	☐	Are you trying to use an electric razor OR avoid shaving the area that is irritated?[2,3]
9. ☐	☐	☐	Are you avoiding waxing or other hair removal creams?[2]
10. ☐	☐	☐	Are you avoiding skin creams or gels in the treatment area before each treatment?[3]
11. ☐	☐	☐	Are you avoiding wet swim wear in the treatment area?[3]
12. ☐	☐	☐	Are you trying to avoid temperature extremes in the treatment area (e.g. ice pack or heating pad) to the reaction area?[2,3]
13. ☐	☐	☐	Are you trying to protect the treatment area from the sun and the cold? [2,3]
14. ☐	☐	☐	Are you trying to use normal saline compresses up to 4 times a day?[2]
15. ☐	☐	☐	Are you trying to avoid tape or Band-aids in the treatment area?[2,3]
16. ☐	☐	☐	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)**

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen Specify:
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Bolderston A, et al. (2006); 2. BC Cancer Agency (2013); 3. ONS-PEP Radiodermatitis (2015); 4. Chan RJ, et al. (2014). (See pages 36-39 for complete references).

Sleep Problems Practice Guide

Name
Date of Birth
Sex

Date and Time

Sleep Problems: actual or perceived changes in night sleep resulting in daytime impairment.[3]

1. Assess severity of the sleep problem **(Supporting evidence: 2 guidelines)**[2,3]

Do you have problems with your sleep for 3 or more nights a week?

☐ Yes ☐ No

If yes, tell me what number from 0 to 10 best describes how much your sleep problem affects your daytime activities at home and work?

No problems 0 1 2 3 4 5 6 7 8 9 10 Worst possible problems with daytime activities [1(ESAS)]

How worried are you about your sleep problem?

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 of impact on daytime activities (see ESAS above)[1-3]	1-3	☐	4-6	☐	7-10	☐
Do you have difficulty falling asleep?[2,3]	<3 nights/week	☐	3+ nights/week	☐	≥30 minutes/night	
Do you have difficulty staying asleep?[2,3]	<3 nights/week	☐	3+ nights/week	☐	≥30 minutes/night	
Early morning waking when not desired?[2,3]	<3 nights/week	☐	3+ nights/week	☐		
How long have these sleep problems been present?[2]	Less than 1 month	☐	More than 1 month	☐		
Did the onset of this problem occur with another issue?[2] Describe.	No	☐	Yes	☐		
Are you taking any medicines that affect sleep (e.g. opiates, steroids, sedatives, etc.) [2]	No	☐	Yes	☐		
Do you have other sleep disorders (e.g., loud snoring, choking/gasping, sleep apnea, restless movement, restless legs)?[2,3]	No	☐			Yes	☐
Are you feeling (symptom risk factors for sleep problems): fatigue, pain, nausea, anxiety, depression, hot flashes[3] If yes, see other symptom practice guide(s).	None	☐	Some	☐	Several, with ≥1 symptoms assessed as severe	☐
	1 **Mild** (Green)		2 **Moderate** (Yellow)		3 **Severe** (Red)	
2. Triage patient for symptom management based on highest severity **(Supporting evidence: 1 guideline)**[2]	☐ Review self-care. ☐ Verify medication use, if appropriate.		☐ Review self-care. ☐ Verify medication use, if appropriate. ☐ Advise to call back if symptom worsens, new symptoms occur, or no improvement in 2-3 days.		☐ Review self-care (If ≥30 minutes see 4.16). ☐ Verify medication use, if appropriate. ☐ For other sleep disorders, refer to sleep disorder clinic.	

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

Additional Comments:

Patient Name_____

3. Review medications patient is using for sleep problems, including prescribed, over the counter, and/or herbal supplements **(Supporting evidence: 2 guidelines)**[2,3]

Current use	Examples of Medications for sleep problems*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
☐	Benzodiazepines - lorazepam (Ativan®), diazepam, (Valium®), alprazolam (Xanax®)[2,3]		Need to balance benefits with harms

*Use of medications for sleep problems should be short term (7-10 days) and depends on side effect profiles of the medicine and the potential for interaction with other current medications.[2,3]

4. Review self-care strategies **(Supporting evidence: 2 guidelines)** [2,3]

Patient already uses	Strategy suggested/ education provided	Patient agreed to try	**Self-care strategies**
1.			What is your goal for sleeping (is it realistic e.g. 6 -10 hours sleep/night)?[2]
2. ☐	☐	☐	What helps when you have problems sleeping? Reinforce as appropriate.
3. ☐	☐	☐	Have you kept a sleep diary?
4. ☐	☐	☐	Do you wake at the same time each day?[2]
5. ☐	☐	☐	Do you get exposed to light soon after waking?[2]
6. ☐	☐	☐	Do you take time to clear your head early in the evening (problem solve, write down plan)?[2]
7. ☐	☐	☐	Do you have a 90 minute buffer zone before intended bedtime (e.g., read, watch TV, crossword puzzle, relax, listen to music, yoga, deep breathing, meditation, guided imagery)?[2]
8. ☐	☐	☐	Do you go to bed when you are sleepy?[2]
9. ☐	☐	☐	Do you limit the use of the bedroom for sleep and/or sex?[2]
10. ☐	☐	☐	If you can't fall asleep within 20-30 minutes, do you get out of bed and return to bed when you are sleepy?[2]
11. ☐	☐	☐	Do you restrict napping in the daytime?[2]
12. ☐	☐	☐	If noisy or too much light, do you use ear plugs or eye masks?[2]
13. ☐	☐	☐	If relevant, do you understand the effect of some medications on sleep?[2] If no, then educate about effect of medications on sleep.
14. ☐	☐	☐	If you have other symptoms, are they under control?[3]
15. ☐	☐	☐	Are you exercising regularly?[3]
16. ☐	☐	☐	Have you tried a program such as cognitive-behavioural therapy (CBT) or received personal counseling that provides more in-depth guidance on managing sleep problems?[2,3]

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

☐	No change, continue with self-care strategies and if appropriate, medication use
☐	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)?
☐	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
☐	Referral (service & date):
☐	Patient agrees to seek medical attention; specify time frame:
☐	Advise to call back in 2-3 days if no improvement, symptom worsens, or new symptoms occur

Name	**Signature**	**Date**

References: 1. Bruera E, et al. (1991); 2. Howell D, et al. (2012); 3. ONS-PEP Sleep-Wake Disturbances (2015). (See pages 36-39 for complete references).

Example General Assessment Form

Practice Guides for the Remote Assessment, Triage, and Management of Symptoms in Adults Undergoing Cancer Treatment

Name
Date of Birth
Sex

Date and time of encounter _____ Caller _____

Type of Cancer _____ Primary Oncologist _____

Other practitioners (most responsible) _____

1. Which symptom(s)

☐ Anxiety	☐ Constipation	☐ Febrile Neutropenia	☐ Peripheral Neuropathy
☐ Appetite Loss	☐ Depression	☐ Mouth sores/Stomatitis	☐ Skin Reaction (Radiation)
☐ Bleeding	☐ Diarrhea	☐ Nausea &Vomiting	☐ Sleep problems
☐ Breathlessness/ Dyspnea	☐ Fatigue/Tiredness	☐ Pain	☐ Other _____

2. Tell me about your symptom(s) (Supporting Evidence: Expert Consensus)
(PQRST- Provoking factors, Quality, Radiating, Relieving factors, Severity, Other symptoms, Timing, Triggers, Location)

3. Conduct general symptom assessment (Supporting Evidence: Expert Consensus)

Receiving cancer treatment:

☐Radiation: Site of radiation _____

☐Chemotherapy: Name of Chemotherapy _____

Date of last treatment(s) _____

Length of time since symptom started? _____

New symptom? ☐Yes ☐No ☐Unsure

Told symptom could occur? ☐Yes ☐No ☐Unsure

Other symptoms? ☐Yes ☐No If Yes, specify:

Recent exposure to known virus/flu? ☐Yes ☐No ☐Unsure If Yes, specify_____

_____

4. Assess current use of medications, herbs, natural health products (name, dose, current use)

Medication	Dose Prescribed	Taking as prescribed/Last dose if PRN
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐No /
		☐Yes ☐No /

Are any medications new or are there recent changes? ☐Yes ☐No If Yes, specify:

_____

5. See appropriate symptom practice guide(s) for further assessment, triage and management.

Full list of references

Anxiety

1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
2. Howell D, et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, July 2015.
3. Oncology Nursing Society (ONS). Putting Evidence into practice (PEP): Anxiety. 2015. PEP Topic updated June 19, 2015: https://www.ons.org/practice-resources/pep/anxiety

Appetite Loss

1. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Anorexia. 2015. PEP Topic updated May 11, 2015: https://www.ons.org/practice-resources/pep/anorexia
2. Dy SM, et al. Evidence-based recommendations for cancer fatigue, anorexia, depression, and dyspnea. J Clin Oncol 2008 Aug 10;26(23):3886-95.
3. Cancer Care Ontario. Symptom Management Guide-to-Practice: Loss of Appetite. Toronto, Ontario; 2012.
4. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.

Bleeding

1. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Prevention of bleeding. PEP Topic updated January 28, 2015: https://www.ons.org/practice-resources/pep/prevention-bleeding
2. Hensley ML, et al. American Society of Clinical Oncology 2008 clinical practice guideline update: use of chemotherapy and radiation therapy protectants. J Clin Oncol 2009 Jan 1;27(1):127-45.
3. Estcourt L, et al. Prophylactic platelet transfusion for prevention of bleeding in patients with haematological disorders after chemotherapy and stem cell transplantation. Cochrane Database Syst Rev 2012;5:CD004269.

Breathlessness/Dyspnea

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Constipation

1. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Constipation. 2015. PEP Topic updated July 29, 2015: https://www.ons.org/practice-resources/pep/constipation
2. Cancer Care Ontario. Symptom Management Guide-to-Practice: Bowel Care. Toronto, Ontario, Canada; 2012.
3. Bruera E, et al. 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. Common terminology criteria for adverse events (CTCAE) v4.03. 2010.

Depression

1. Bruera E, et al. The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients. J Palliat Care 1991;7(2):6-9.
2. Howell D, et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, July 2015.
3. Oncology Nursing Society (ONS). Putting evidence into practice (PEP): Depression. 2015. PEP Topic updated June 19, 2015: https://www.ons.org/practice-resources/pep/depression

Diarrhea

1. Major P, et al. The Role of Octreotide in the Management of Patients with Cancer: Practice Guideline Report #12-7. Cancer Care Ontario, Program in Evidence Based Care; 2004.
2. Keefe DM, et al. Updated clinical practice guidelines for the prevention and treatment of mucositis. Cancer 2007 Mar 1;109(5):820-31.
3. Benson AB, III, et al. Recommended guidelines for the treatment of cancer treatment-induced diarrhea. J

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10. Lalla RV, et al. MASCC/ISOO clinical practice guidelines for the management of mucositis secondary to cancer therapy. Cancer 2014 May 15;120(10):1453-61.
11. Vehreschild MJ, et al. Diagnosis and management of gastrointestinal complications in adult cancer patients: evidence-based guidelines of the Infectious Diseases Working Party (AGIHO) of the German Society of Hematology and Oncology (DGHO). Ann Oncol 2013 May;24(5):1189-202.

Fatigue/Tiredness

1. Howell D, et al. Pan Canadian Practice Guideline for Screening, Assessment, and Management of Cancer-Related Fatigue in Adults Version 2-2015, Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology, April 2015.
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Febrile Neutropenia

1. Freifeld AG, et al. Clinical practice guideline for the use of antimicrobial agents in neutropenic patients with cancer: 2010 update by the infectious diseases society of america. Clin Infect Dis 2011 Feb 15;52(4):e56-e93.
2. National Comprehensive Cancer Network. Clinical practice guidelines in oncology: Prevention and treatment of cancer-related infections. Version 2. 2015
3. Flowers, C. R., et al. (2013). Antimicrobial prophylaxis and outpatient management of fever and neutropenia in adults treated for malignancy: American Society of Clinical Oncology clinical practice guideline. J Clin Oncol, 31(6), 794-810.
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Nausea & Vomiting

1. Basch E, et al. Antiemetics: ASCO clinical practice guideline update. J Clin Oncol 2011 Nov 1;29(31):4189-98.
2. National Comprehensive Cancer Network. Clinical practice guidelines in oncology: antiemesis. Version 2. 2015.
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