Figure 1- PCCT: IN Patient – Data Collection Form

Date of Admit: ____/____/_____ (dd mm yyyy) **Date of Referral:** ____/____/_____ (dd mm yyyy) **Date of Consult:** ____/____/_____ (dd mm yyyy)

Triage Urgency: ☐ *Emergent* (within hours) ☐ *Urgent* (same day) ☐ *Non-Urgent* (next day)
(as indicated by APN or referring clinician)

Patient Preference for Translation: _____

Community physician providing PC: ☐ Yes ☐ No ☐ Unknown

If yes, name: _____ **Affiliation:** ☐ Family Doctor ☐ TLCPC ☐ Other: _____

Reason for Referral:
- ☐ *Pain*
- ☐ *Decision Making*
- ☐ *Discharge Planning*
- ☐ *End of Life Care*
- ☐ *Psychosocial/Family Support*
- ☐ *Symptom Management*

Symptoms Identified:
- ☐ *Shortness of breath*
- ☐ *Delirium*
- ☐ *Nausea/Vomiting*
- ☐ *Depression*
- ☐ *Anxiety*
- ☐ *Fatigue*
- ☐ *Anorexia (poor appetite)*
- ☐ *Constipation*
- ☐ *Secretions*
- ☐ *Malignant Pain*
- ☐ *Post Herpetic Neuralgia*
- ☐ *Non malignant, non Tx related Pain*
- ☐ *Post Treatment Pain:*
  - ☐ *Post Surgical*
  - ☐ *Post Chemotherapy*
  - ☐ *Post Radiation*
  - ☐ *Uncertain*

Referred From:
- ☐ Acute Pain Service
- ☐ B4ICU
- ☐ B5ICU
- ☐ Cardiac Surgery
- ☐ Cardiology
- ☐ CCU
- ☐ CRCU
- ☐ CVICU
- ☐ D4ICU
- ☐ Emerg
- ☐ ENT
- ☐ General Surgery
- ☐ Geriatric Medicine
- ☐ GI
- ☐ GIM
- ☐ Gyne Onc
- ☐ Haem Onc
- ☐ K1E
- ☐ Long Term Care
- ☐ Med Onc
- ☐ Nephrology
- ☐ Neurosurgery
- ☐ OP PCCT
- ☐ Orthopedics
- ☐ Psychiatry
- ☐ Rad Onc
- ☐ Rapid Response
- ☐ Respirology
- ☐ Rheumatology
- ☐ Surg Onc
- ☐ TLCPC
- ☐ Urology
- ☐ Vascular Surgery

Referred from:

If Oncology *(choose one)*: ☐ RN ☐ Hospitalist/GPO _____ ☐ Attending/Fellow/Resident _____

If Non Oncology: ☐ Name of Attending: _____

Primary PCCT Consultant(s): _____ **Secondary PCCT Consultant(s):** _____ **Trainee** ☐

Previous Advanced Directive Discussion

☐ Yes ☐ No

If Yes, Status:
- ☐ Living Will
- ☐ Code Status
- ☐ DNR
- ☐ Full Code

PPS
100
90
80
70
60
50
40
30
20
10

Anticipated Prognosis
- ☐ Hrs
- ☐ Days (< 1 wk)
- ☐ Wks (1-4 wks)
- ☐ 1-3 months
- ☐ 3-6 months
- ☐ 6-12 months
- ☐ > 12 months

Intent of Care
- ☐ Curative
- ☐ Palliative
- ☐ Unknown
- ☐ No active disease

Underlying illness: Diagnostic Code: _____ *(for primary referring diagnosis)*

☐ **Malignant**

Primary Cancer Site: _____

Date of Initial Cancer Diagnosis: _____/_____
mm yyyy

☐ **Non-malignant**

Diagnosis: _____

Date of Diagnosis: ____/_____ OR ☐ Years
mm yyyy

Date of First Diagnosis of Metastases *(date of radiology report):* _____/_____
mm yyyy

Sites of Metastases *(current sites):*

☐ Bone ☐ Soft Tissue (incl. nodes) ☐ Brain
☐ Lungs ☐ Liver ☐ Pleura
☐ Peritoneum ☐ Locally Advanced ☐ Leptomeninges ☐ Other:_____

Other Malignancy Related Complications *(if yes, circle past/present)*

☐ MBO (Current/Past)
☐ Spinal Cord Compression (Current/Past)
☐ Hypercalcemia (Current/Past)
☐ Biliary Obstruction (Current/Past)
☐ Ureteric Obstruction (Current/Past)
☐ SVC Syndrome (Current/Past)
☐ Other_____(Current/Past)

Does the patient have?

☐ Biliary Stent/Drain
☐ Feeding G-tube
☐ GI Stent (location:_____)
☐ PICC Line/Central Line
☐ Pigtail Catheter
☐ Tracheostomy
☐ Ongoing need for O_2
☐ Ureteric Stent/Nephrostomy
☐ Venting G-tube
☐ Colostomy/Ileostomy
☐ Other:_____

	YES	*<3 months*	*3-6 months*	*>6 months ago*	**NO**
Chemotherapy:	☐	☐	☐	☐	☐
Surgery:	☐	☐	☐	☐	☐
Radiation Treatment:	☐	☐	☐	☐	☐

Disposition:

☐ Home
☐ Home with home care referral
☐ Home with PC referral
☐ Signed off
☐ Transferred to K1E
☐ Transferred to Other PCU
☐ Transferred to Hospice
☐ Died in hospital

Disposition Date: _____