Patient Intake Assessment Tools for Navigation

Review and utilize the following with new patient referrals to the Navigation program:

- **Psychosocial Distress Screening Tool**: Commission on Cancer Standard 3.2, patients with cancer are offered screening for distress a minimum of 1 time per patient at a pivotal medical visit to be determined by the program.

- **Barriers to Care**: Commission on Cancer Standard 3.1 under Patient Navigation Process, refers to individualized assistance offered to patients, families and caregivers to help overcome health care system barriers and facilitate timely access to quality medical and psychosocial care and can occur from prior to a cancer diagnosis through all phases of the cancer experience. (example tool attached)

- Patient Navigation Intake Form (attached)

- **Review of Support Services at Your Cancer Program and Community**
Review the Support Staff and Services Available at Your Cancer Program:

- Nurse Navigator
- Social Worker
- Financial Assistant
- Registered Dietitian
- Health Psychologist
- Genetic Counselor
- Pastoral Care
- Health Coaches
- Survivorship Program
- Rehabilitation
- Resource Library
- Pain and Symptom Management
- Palliative Care
- Support Groups
- Educational programs
- Resource Library
- Wig Bank

Other: ________________________________________________________________

Any specific support staff or services needed right now? What can we help you with right now?

_____________________________________________________________________________

_____________________________________________________________________________
**Patient Navigation Intake Form**
Complete this form with the patient at time of initial contact

Name: ____________________________________________________________

Address: __________________________________________________________

Telephone number(s): ________________________________________________

Can messages be left at this phone number?  ❑ Yes ❑ No

Emergency contact person: ____________________________________________

Emergency contact number: __________________________________________

1. **How was patient referred to the patient navigation program?**

   ❑ Physician  Name: ________________________________________________

   ❑ Hospital  Name: ________________________________________________

   ❑ CEED  Name of center: __________________________________________

   ❑ Nurse  Name and department: ______________________________________

   ❑ Social worker  Name: ____________________________________________

   ❑ Other  Please explain: ____________________________________________

2. **What has your doctor told you so far? Diagnosis:**

   Biopsy Date/Result: ________________________________________________

   Tumor Markers Date/Result: ________________________________________

   Binder Reviewed (date): ____________________________________________

3. **Does patient have health insurance?**  ❑ Yes ❑ No

   If yes, is it:

   ❑ Private/Commercial  ❑ Medicare  ❑ Medicaid

   Other: ___________________________________________________________

**Potential Problems/Barriers to Care**
This list is to be used to help you to identify patient concerns at the initial visit and at each follow-up visit. It will help you develop a plan of action, including referrals to appropriate departments.
**Family History:**
- Meets NCCN Guidelines for referral to Genetics

**Supportive Services for Referrals:**
- Social Worker
- Clergy
- Look Good Feel Better
- Second Opinion Service
- Nutritionists
- Support Partner
- Support Group
- Strength After Breast Cancer
- Genetics
- Reach to Recovery
- American Cancer Society
- Financial Counselors
- Next Step Cancer Fitness
- Lymphedema
- Pre-op Classes
- LifeCare
- Research

**Appointments Scheduled and Dates:**

Surgery: ____________________________
- Type: ____________________________

Pre-op Testing: ____________________________

Sentinel Node Injection: ____________________________

MRI: ____________________________

ECHO: ____________________________

CT Scan: ____________________________

Bone Scan: ____________________________

Surgeon: ____________________________

Plastic Surgeon: ____________________________
MED ONC Consult: ________________________________________________________________

Rad ONC Consult: _______________________________________________________________

**Plan of Care and Follow Up:**

1. __________________________________________________

2. __________________________________________________

3. __________________________________________________

4. __________________________________________________

5. __________________________________________________

**Patient Navigation Intake Form (Continued)**

**Comments:**

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

**Tracking Tool**

Refer to POTENTIAL PROBLEMS/BARRIERS TO CARE to explore patient concerns. Record the results of each intervention or visit with the patient.

Patient name and identification: __________________________________________________

Date: _______________________________________________________________________

Reason for visit: _______________________________________________________________________

Barrier/concern identified: ____________________________________________________________

Action to be taken: _________________________________________________________________

Desired result: _________________________________________________________________

Resolution and date: ___________________________________________________________

Additional comments: ____________________________________________________________
Health Insurance/Financial Concerns
- Inadequate or lack of insurance coverage
- Pre-certification problems
- Difficulty paying bills
- Need for financial assistance from Medicaid/Medicare
- Confusing financial paperwork
- Need for medical equipment or supplies (wheelchairs, dressings)
- Citizenship problems/undocumented status
- Other: ________________________________

Transportation To and From Treatment
- Public transportation needed
- Private transportation needed
- Other: ________________________________

Physical Needs
- Child/elder care
- Housing/housing problems
- Food, clothing, other physical needs
- Prostheses, wigs, etc.
- Vocational support (job skills, employment skills)

Communication/Cultural Needs
- Primary language other than English
- Inability to read/write
- Poor health literacy
- Cultural barriers (i.e., effect on lifestyle choices)
- Other: ________________________________

DISEASE MANAGEMENT

Treatment Compliance Issues (Missed appointments, etc.)
- Needs help with obtaining a second opinion (if desired by patient)
- Mental health services needed
- Does not understand treatment plan and/or procedures
- Needs to talk to provider (physician, nurse, therapist, etc.)
- Wants more information about: ________________________________
- Other: ________________________________
**Patient Education:**

Patient Treatment Journal and Educational Materials Provided: Yes ___ No ____
If so what educational materials were provided?

__________________________________________________________________________

__________________________________________________________________________

**National and Government Oncology Resources for Patients, Families and/or Caregivers, examples:**

The Cancer Support Community
The American Cancer Society
The Leukemia and Lymphoma Society
National Cancer Institute
National Comprehensive Cancer Network
Commission on Cancer
Other: ______________________________________________________________________