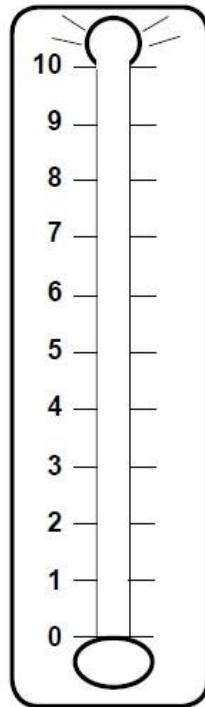


## NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress



No distress

## PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

### YES NO Practical Problems

- ☐ ☐ Child care
- ☐ ☐ Housing
- ☐ ☐ Insurance/financial
- ☐ ☐ Transportation
- ☐ ☐ Work/school
- ☐ ☐ Treatment decisions

### Family Problems

- ☐ ☐ Dealing with children
- ☐ ☐ Dealing with partner
- ☐ ☐ Ability to have children
- ☐ ☐ Family health issues

### Emotional Problems

- ☐ ☐ Depression
- ☐ ☐ Fears
- ☐ ☐ Nervousness
- ☐ ☐ Sadness
- ☐ ☐ Worry
- ☐ ☐ Loss of interest in usual activities

- ☐ ☐ Spiritual/religious concerns

Other Problems: \_\_\_\_\_

### YES NO Physical Problems

- ☐ ☐ Appearance
- ☐ ☐ Bathing/dressing
- ☐ ☐ Breathing
- ☐ ☐ Changes in urination
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Eating
- ☐ ☐ Fatigue
- ☐ ☐ Feeling swollen
- ☐ ☐ Fevers
- ☐ ☐ Getting around
- ☐ ☐ Indigestion
- ☐ ☐ Memory/concentration
- ☐ ☐ Mouth sores
- ☐ ☐ Nausea
- ☐ ☐ Nose dry/congested
- ☐ ☐ Pain
- ☐ ☐ Sexual
- ☐ ☐ Skin dry/itchy
- ☐ ☐ Sleep
- ☐ ☐ Substance abuse
- ☐ ☐ Tingling in hands/feet

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Which of these are your most **important** concerns right now?

Have you previously had treatment for emotional concerns? ☐ Yes ☐ No

## SUPPORTIVE CARE SCREENING

To be complete by the patient, or with the patient

<Insert hospital logo here>

Surname: .....

Given Names: .....

Date of Birth: ..... Sex: .....

UR No: ..... (AFFIX PATIENT LABEL HERE)

DATE COMPLETED: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SIGNATURE: \_\_\_\_\_

<Insert hospital logo here>

## Kessler Psychological Distress Scale K10

(To only be completed for patients who have a score **greater or equal to 4** on the Distress Thermometer above)

**For all the questions below please indicate the response which best describes you mood over the past four (4) weeks.**

In the past four (4) weeks:		All of the time (5)	Most of the time (4)	Some of the time (3)	A little of the time (2)	None of the time (1)
1	How often did you feel tired out for no good reason?					
2	How often did you feel nervous?					
3	How often did you feel so nervous that nothing could calm you down?					
4	How often did you feel hopeless?					
5	How often did you feel restless or fidgety?					
6	How often did you feel so restless you could not sit still?					
7	How often did you feel depressed?					
8	How often did you feel that everything was an effort?					
9	How often did you feel so sad that nothing could cheer you up?					
10	How often did you feel worthless?					
TOTAL SCORE						

A score of < 16: indicates persons with no increased likelihood of anxiety or depressive disorder.

A score of 16-30: indicates persons with three times the population risk of having a current anxiety or depressive disorder

A score of 31-50: indicates persons with ten times the population risk of having a current anxiety or depressive disorder

### FOR STAFF ONLY

Have you discussed the patient's distress and concerns? ☐ Yes ☐ No

Referral to GP if K10  $\geq$  16 &/or there are issues to be addressed? ☐ Yes ☐ No

Have any other referrals been made? ☐ Yes ☐ No

If yes, list which provider(s): \_\_\_\_\_

Notes: \_\_\_\_\_

Staff Member: .....

Ward/Unit: .....

Screening Offered but declined: ☐

DATE COMPLETED: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SIGNATURE: \_\_\_\_\_