Symptom Assessment Sheet

No.

Day Month

Regional Refferal Clinical Pathway / Medical Record

[Daily goal] Leading daily life safely and comfortably		Yes	No	Yes	No	Yes	No
[Goals]	To increase the hours of pain-free sleep	☐	☐	☐	☐	☐	☐
	To relieve the pain when the patient is at rest	☐	☐	☐	☐	☐	☐
	To relieve the pain when the patient is standing or active	☐	☐	☐	☐	☐	☐
	To improve in symptoms other than pain	☐	☐	☐	☐	☐	☐
[Criteria for the assessment of subjective symptoms] (STAS) Physical distress	Mean duration of sleep: Longer than 3/4 of ( ) hours	☐	☐	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Less than 3 times of awakening at night	☐	☐	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Rest pain 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Movement-related pain 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Drowsiness 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Systemic fatigue 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Dyspnea 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Coughing 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Appetite loss 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Itchy sensation 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Constipation 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Diarrhea 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Nausea / vomiting 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
Mental distress	Depression 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4
	Anxiety 0-1 times	☐0.1	☐2.3.4	☐0.1	☐2.3.4	☐0.1	☐2.3.4

Medical Record Sheet

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[Analgesics]	Opioids (regularly administered)		Yes / No	Yes / No	Yes / No
	Analgesics for temporary use ("rescue"):	Mark the time of administration			
		Drug name (dose)	(mg)	(mg)	(mg)
	Patch changes:	Mark the time of change			
		Patch name (dose)	(mg)	(mg)	(mg)
	Complementary drugs		Yes / No	Yes / No	Yes / No
		Drug name (dose)	(mg)	(mg)	(mg)
[Fluid infusions]	When administered => (TPN / PPN)		TPN / PPN	TPN / PPN	TPN / PPN
Yes / No	CV-port		Yes / No	Yes / No	Yes / No
[PCA pump]	PCA pump	Mark the time of change			
Yes / No	Dosing times (Number of self-administration with or without the drug)		( ) times	( ) times	( ) times
	Valid dosing times (Number of self-administration with the drug)		( ) times	( ) times	( ) times
[Vital signs]	Blood pressure (systolic / diastolic)		(/)	(/)	(/)
	Pulse (times / minute)		( ) times/minute	( )times/minute	( )times/minute
	Body temperature (℃)		( ) ℃	( ) ℃	( ) ℃
	Home oxygen therapy (HOT)		Yes / No ( ) ℓ	Yes / No ( ) ℓ	Yes / No ( ) ℓ
	Oxygen saturation level SpO_2 (%)		( ) %	( ) %	( ) %
Signature / Time			/	/	/

STAS, support team assessment schedule; TPN, total parenteral nutrition; PPN, paripheral parenteral nutrition; CV, central venous; PCA, patient controlled analgesia

Descriptive Sheet

Free Description / MDT Progress

◆ Patient and family: To describe freely your questions, anxiety, and other issues.

◆Visiting nurse, care manager, medical social worker, nutritionist, pharmacist, and caregiver: To write massages for the patient/family.

◆To fill out special notes regarding consultation (visiting consultation, daily life guidance, etc.).

MDT, multi-disciplinary team

Fig.1 Overview of Regional Refferal Clinical Pathway for Palliative Home/care for one day (Symptom Assessment Sheet, Medical Record Seet, Descriptive Sheet)