Appendix A: Sample Assessments

Patient Version

IPOS Patient Version

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STAFF COMPLETED
Practice Site Name: ..... Patient Identification #: .....
Assessment Date: ..... Setting: ❑ Office ❑ Nursing home
Assessment Type (check): ❑ Initial ❑ Status Change ❑ Routine
Insurance Type (check all that apply): ❑ Commercial ❑ Medicaid ❑ Medicare ❑ Uninsured

Q1. What have been your main problems or concerns over the past week?

1. _____
2. _____
3. _____

Q2. Below is a list of symptoms, which you may or may not have experienced. For each symptom, please tick one box that best describes how it has affected you over the past week.

	Not at all	*Slightly*	*Moderately*	*Severely*	*Over-whelmingly*	STAFF COMPLETED *Intervention offered or provided?*
Pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Shortness of breath	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Weakness or lack of energy	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Nausea (feeling like you are going	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Vomiting (being sick)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Poor appetite	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Constipation	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Sore or dry mouth	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Drowsiness	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Poor mobility	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes

Please list any other symptoms not mentioned above, and tick one box to show how they have affected you over the past week.

1. _____	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
2. _____	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
3. _____	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes

Over the past week:

	Not at all	Occasionally	Sometimes	Most of the time	Always	STAFF COMPLETED Intervention offered or provided?
Q3. Have you been feeling anxious or worried about your illness or treatment?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Q4. Have any of your family or friends been anxious or worried about you?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Q5. Have you been feeling depressed?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes

	Always	Most of the time	Sometimes	Occasionally	Not at all	STAFF COMPLETED Intervention offered or provided?
Q6. Have you felt at peace?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Q7. Have you been able to share how you are feeling with your family or friends as much as you wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes
Q8. Have you had as much information as you wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes

	Problems addressed/ No problems	Problems mostly addressed	Problems partly addressed	Problems hardly addressed	Problems not addressed	STAFF COMPLETED Intervention offered or provided?
Q9. Have any practical problems resulting from your illness been addressed? (such as financial or personal)	☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes

	Health Care Proxy	Living Will	Organ Donation	Documentation of Oral Advance Directive	None	STAFF COMPLETED Intervention offered or provided?
Q10 Check all advance directives known to have been completed:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐ No ☐ Yes

	On my own	With help from a friend or relative	With help from a member of staff
Q11 How did you complete this questionnaire?	☐	☐	☐

If you are worried about any of the issues raised on this questionnaire then please speak to your doctor or nurse