Staff Version

IPOS Staff Version

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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 the patient's main problems over the past week?

1. _____
2. _____
3. _____

Q2. Please tick one box that best describes how the patient has been affected by each of the following symptoms over the past week

	Not at all	Slightly	Moderately	Severely	Over-whelmingly	Cannot assess (e.g. unconscious)	Intervention offered or provided?
Pain	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Shortness of breath	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Weakness or lackof energy	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Nausea (feeling like you are going to be sick)	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 and tick one box to show how you feel each of these symptoms has affected the patient 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	Cannot assess (e.g. unconscious)	Intervention offered or provided?
Q3. Has s/he been feeling anxious or worried about his/her illness or treatment?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Q4. Have any of his/her family or friends been anxious or worried about the patient?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Q5. Do you think s/he felt depressed?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes

	Always	Most of the time	Sometimes	Occasionally	Not at all	Cannot assess (e.g. unconscious)	Intervention offered or provided?
Q6. Do you think s/he has felt at peace?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Q7. Has the patient been able to share how s/he is feeling with his/her family or friends as much as s/he wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes
Q8. Has the patient had as much information as s/he wanted?	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes

	Problems addressed/ No problems	Problems mostly addressed	Problems partly addressed	Problems hardly addressed	Problems not addressed	Cannot assess (e.g. unconscious)	Intervention offered or provided?
Q9. Have any practical problems resulting from his/her illness been addressed? (such as financial or personal)	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes

	Health Care Proxy	Living Will	Organ Donation	Documentation of Oral Advance Directive	None	Cannot assess (e.g. unconscious)	Intervention offered or provided?
Q10. Check all advance directives known to have been completed:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	☐	☐ No ☐ Yes