Radiation therapy nursing baseline assessment form

This nursing assessment form should be completed prior to the patient commencing radiation therapy.

Please refer to the appropriate eviQ treatment protocol and patient information sheet.

Hospital ID: **MRN:**

Surname:

Given names:

Date of birth: **Sex:** **AMO:**

Date:

Diagnosis:

Pronouns:

Preferred names:

Patient and carer education and information checklist	Yes	No	N/A	TBC
Consent for radiation therapy completed (as per institutional policy)	☐	☐		
Medical history (including medications and allergies) documented	☐			☐
Cardiac implantable electronic device information documented in patient's record (if applicable)	☐		☐	☐
Pregnancy status documented (if applicable)	☐		☐	☐
Smoking cessation discussed (if applicable)	☐	☐	☐	
Advanced care directive/resuscitation plan documented	☐		☐	☐
eviQ radiation therapy patient education checklist completed	☐	☐	☐	

Social history
Resides with
Place of residence during treatment
Anticipated transport

Comprehensive assessment	Yes	No	N/A
Baseline observations completed (e.g. temperature, pulse, BP, respiratory rate, SpO2, height, weight, ECOG)	☐	☐	
Pain assessment completed	☐	☐	
Pressure wound assessment completed	☐	☐	
Falls risk assessment completed	☐	☐	
Sexual dysfunction discussed	☐	☐	☐
Psycho-social concerns discussed	☐	☐	

Concurrent treatment	Yes	No
Concurrent therapy	☐	☐
If **yes** - protocol/regimen		
start date		
treatment plan in place	☐	☐
medical oncology followup		
Participating in a clinical trial	☐	☐
details		

Referrals

Service	Existing referral	Referral required	Contact name/number	Referred by	Date referred
Care coordinator					
Dietitian					
Speech pathologist					
Social worker					
Quitline					

Additional notes	
Plan for ongoing nursing assessment (e.g daily, weekly, as needed)	
Plan for treatment reviews (e.g weekly, fortnightly & by who)	

Name	Signature	Date

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