Radiation therapy nursing baseline assessment form

	Hospital ID: MRN: Surname: Other names: DOB: Sex:

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

Date			
Diagnosis			
Consent for radiation therapy completed (as per institutional policy)	Yes	No	
Medical history (including medications and allergies) documented	Yes	TBD	
Cardiac implantable electronic device information documented in patient's record (if applicable)	Yes	TBD	N/A
Pregnancy status documented in patient's record (if applicable)	Yes	TBD	N/A
Smoking cessation discussed (if applicable)	Yes	No	N/A
Advanced care directive/resuscitation plan documented in patient's record	Yes	TBD	N/A
eviQ radiation therapy patient education checklist completed	Yes	No	N/A
Social history			
Resides with			
Place of residence during treatment			
Anticipated transport			
Comprehensive assessment			
Baseline observations completed (e.g. temperature, pulse, BP, respiratory rate, SpO2, height, weight, ECOG)	Yes	No	
Pain assessment completed	Yes	No	
Pressure wound assessment completed	Yes	No	
Falls risk assessment completed	Yes	No	
Sexual dysfunction discussed	Yes	No	N/A
Psycho-social concerns discussed	Yes	No	
Concurrent treatment			
Concurrent therapy	Yes	No	
If **yes** - protocol/regimen			
start date			
treatment plan in place	Yes	No	medical oncology follow up:
Participating in a clinical trial	Yes	No	Details:

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Referrals					
Service	**Existing referral in place** **Yes/No**	**Referral required** **Yes/No**	**Contact name & number/pager**	**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 whom)					

Name:…….. **Signature:……** **Date:……**