



HEALTH CARE PERSONNEL FORM

Patient's:		Please fill in or tick the right box as appropriate
18	Date of birth	(Day.Month.Year)
19	Principal diagnosis	ICD-10 code:
20	Date of the principal diagnosis	(Month.Year)
21	Stage of the cancer disease	<input type="checkbox"/> Local <input type="checkbox"/> Locally advanced <input type="checkbox"/> Metastatic/disseminated
22	Site of metastases	<input type="checkbox"/> Bone <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> CNS <input type="checkbox"/> Other
23	Present anticancer treatment	<input type="checkbox"/> Radiotherapy <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Hormone therapy <input type="checkbox"/> Other anticancer therapy <input type="checkbox"/> No anticancer therapy
24	Additional diagnoses	ICD-10 code: _____, _____, _____, _____, _____, _____, _____
25	Stage of the non-cancer disease	Chronic heart failure (CHF): The New York Heart Association (NYHA) Functional Classification; NYHA class: I <input type="checkbox"/> , II <input type="checkbox"/> , III <input type="checkbox"/> , IV <input type="checkbox"/>
		Chronic obstructive pulmonary disease (COPD): GOLD classification; stage: I <input type="checkbox"/> , II <input type="checkbox"/> , III <input type="checkbox"/> , IV <input type="checkbox"/>
		Dementia: FAST scale; stage: 1 <input type="checkbox"/> , 2 <input type="checkbox"/> , 3 <input type="checkbox"/> , 4 <input type="checkbox"/> , 5 <input type="checkbox"/> , 6 <input type="checkbox"/> , 7 <input type="checkbox"/>
26	Medication	<input type="checkbox"/> Non-opioid analgesics <input type="checkbox"/> Opioids <input type="checkbox"/> Co-analgetics <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Antidepressants <input type="checkbox"/> Antiemetics <input type="checkbox"/> Neuroleptics <input type="checkbox"/> Sedatives/anxiolytics <input type="checkbox"/> Drug(s) for acid related disorders <input type="checkbox"/> Laxatives



BASIC DATASET

		<input type="checkbox"/> Antibiotics <input type="checkbox"/> Diuretics <input type="checkbox"/> Heart medication / antihypertensives <input type="checkbox"/> Other
27	Weight loss	Involuntary weight loss ____ % and duration of weight loss ____ months
28	Performance status	<input type="checkbox"/> 100 Normal; no complaints; no evidence of disease. <input type="checkbox"/> 90 Able to carry on normal activity; minor signs or symptoms. <input type="checkbox"/> 80 Normal activity with effort; some signs or symptoms of disease <input type="checkbox"/> 70 Cares for self; unable to carry on normal activity or to do active work. <input type="checkbox"/> 60 Requires occasional assistance but is able to care for most of his needs. <input type="checkbox"/> 50 Requires considerable assistance and frequent medical care. <input type="checkbox"/> 40 In bed more than 50% of the time. <input type="checkbox"/> 30 Almost completely bedfast. <input type="checkbox"/> 20 Totally bedfast and requiring extensive nursing care by professionals and/or family. <input type="checkbox"/> 10 Comatose or barely arousable. <input type="checkbox"/> 0 Dead
29	Cognitive function	The patient has cognitive impairment; <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
30	Place of care	<input type="checkbox"/> Home <input type="checkbox"/> Long-term care facilities <input type="checkbox"/> Hospice / Palliative care unit <input type="checkbox"/> Hospital <input type="checkbox"/> Other
31	Provision of care	<input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Day care