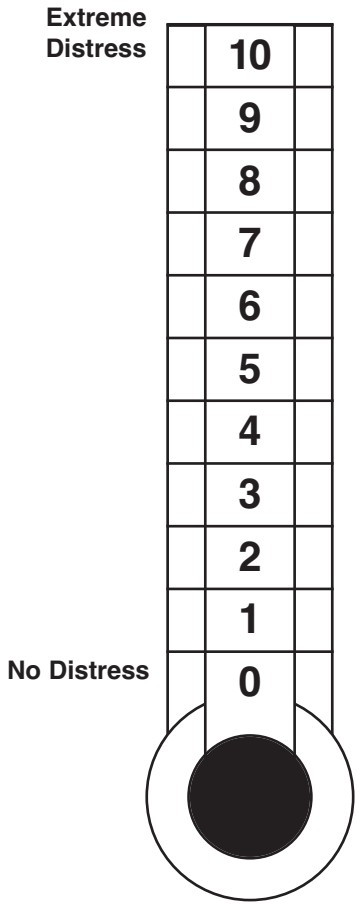
TOBACCO FREE CAMPUS

Patient Name: _____ Date: _____ Time: _____

Instructions: First, please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



FOR MD COMPLETION

Clinical Use Only:

- ❑ **0-4 - Supportive Care**
- ❑ **5-7 - Patient Navigator (ext. 95857)**
- ❑ **8-10 - Triage by M.D. (LW ext. 91360)**

MD Signature: _____

Date: _____

Time: _____

Dictation #: _____

*Second, please indicate if any of the following has been a problem for you in the past week including today. Be sure to check **YES** or **NO** for each.*

YES	NO	Practical Problems:
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems:
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems:
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/religious concerns**

YES	NO	Physical Problems:
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urniation
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling Swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Tingling in hands/feet

Notes: _____

_____

Nurse Signature: _____ **Date:** _____ **Time:** _____

Northeast Georgia Medical Center

Northeast Georgia PHYSICIANS GROUP

SCREENING TOOLS FOR MEASURING DISTRESS

PATIENT IDENTIFICATION:

529-01324