

Oncology North: Navigator Intake Paper Form

PATIENT NAVIGATION INTAKE FORM

Primary Care Provider:		
Information provided by:		Race/Ethnicity:
Patient	Other	M / F
Name:		<input type="checkbox"/> Patient <input type="checkbox"/> Significant Other <input type="checkbox"/> Caregiver
Address:		
DOB:	Age:	
Home:	Work:	Cell:
Can messages be left at this phone number? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Emergency contact person:		Relationship:
Who can information be shared with?		

Cancer History

Type of Cancer	Metastases:
Stage:	Date of Diagnosis:
Status: <input type="checkbox"/> New <input type="checkbox"/> Ongoing Tx <input type="checkbox"/> Post Tx	Date of Recurrence:

Treatment:

Surgery/Type:	Dates:	Surgeon:
Chemotherapy/Drugs:	Dates:	Provider:
Radiation Therapy:	Dates:	Provider:
Other Providers:		

Financial Information:

Primary Ins:	Secondary Ins:
Referral Source:	Date of Referral:

PATIENT NAVIGATION INTAKE FORM

Authorization process: _____

How do you feel patient navigation can best help you? _____

What information has your doctor told you regarding your diagnosis so far? _____

How do you prefer to learn? ☐ Verbal ☐ Reading ☐ Handout ☐ Video ☐ Other _____

Do you have access to a computer? ☐ yes ☐ no Do you prefer to communicate by computer? ☐ yes ☐ no

Potential Problems/Barriers To Care

Health Insurance/Financial Concerns

- ☐ Inadequate or lack of insurance coverage
- ☐ Precertification problems
- ☐ Difficulty paying bills
- ☐ Need for financial assistance from Medicaid/Medicare/AHCCCS
- ☐ Assistance with completing financial paperwork
- ☐ Need for prescription assistance
- ☐ Need for medical equipment or supplies (wheelchairs, dressings)
- ☐ Other: _____

Work Issues

- ☐ Job responsibilities
- ☐ FMLA paperwork
- ☐ Vocational support (job skills, employment skills)

Transportation To and From Treatment

- ☐ Public transportation needed
- ☐ Private transportation needed
- ☐ Other: _____

Physical Needs

- ☐ Child/elder care
- ☐ Housing/housing problems
- ☐ Food, clothing, other physical needs
- ☐ Assistance with tube feedings/supplies/DME/medical supplies
- ☐ Protheses, wigs, etc (CPT codes)
- ☐ Extended care needs: home care, hospice, long-term care, LTAC
- ☐ Other: _____

Communication/Cultural Needs

- ☐ Primary language _____
- ☐ Inability to read/write _____
- ☐ Hearing/vision loss _____
- ☐ Cultural barriers (i.e., effect on lifestyle choices/religious/dietary/ethnicity)
- ☐ Other: _____

Disease Management

- ☐ Treatment compliance issues (missed appointments, unwillingness to take medicine)
- ☐ Needs help with obtaining a second opinion (if desired by patient)
- ☐ Does not understand treatment plan and/or procedures
- ☐ Needs to talk to provider (physician, nurse, therapist, etc)
- ☐ Wants more information about: _____
- ☐ Other: _____

Psychosocial

- ☐ Psychosocial/Mental health services needed
- ☐ current provider _____ ☐ needs referral _____
- ☐ Spiritual care ☐ needs referral _____

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- ☐ Spiritual care ☐ needs referral _____

PATIENT NAVIGATION INTAKE FORM

Fatigue

On a scale of 0-10, what do you rate your current state of fatigue in past 24 hours? _____

When do you feel most fatigued? (morning, afternoon, evening) _____

What activities contribute to your fatigue? (bathing, household chores, walking, stairs, etc) _____

Do you take enough rest periods during the day? ☐ Yes ☐ No When _____ Number _____

What time do you typically wake and go to bed? _____

Comment: _____

Spiritual/Religious

Do you have a religious preference? ☐ Yes ☐ No If so, what? _____

Do you believe in a higher power? (God or other as defined by patient) _____

Has receiving this diagnosis affected your religious/spiritual beliefs? ☐ Yes ☐ No

If yes, in what ways? _____

Do you have a sense of: _____ hope _____ fear _____ uncertainty _____ anxiety _____ unsure

How would you describe your support system? _____ Excellent _____ Good _____ Fair _____ Poor

Comment: _____

Place of worship _____

Research Participation

Is patient a candidate for clinical trials: ☐ Yes ☐ No

Has patient already been determined and accepted for clinical trials? ☐ Yes ☐ No

Is patient interested in learning about clinical trial participation? ☐ Yes ☐ No If so, refer to (Clinical Research Nurse?):

Comment: _____

Plan of Care/Follow-up/Referrals

1. _____

2. _____

3. _____

4. _____

Education and printed information provided:

1. _____

2. _____

3. _____

4. _____

Additional Comments:

