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Queensland Government

ADOLESCENT AND YOUNG ADULT ONCOLOGY SCREENING TOOL

Facility: ....

(Affix identification label here)

URN:

Family name:

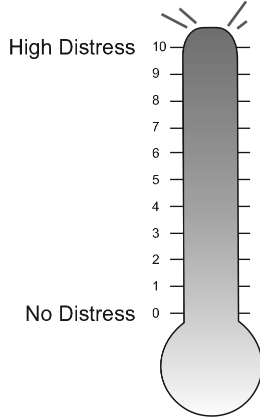
Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

1. General Distress

How much distress have you been feeling over the past week? (circle a number from 0 to 10)



Office Use Only:			
Date of Assessment			
Date of Next Assessment			
Information Provided:			
Clinical trials		Alcohol and drug use	
Support organisations		Fertility preservation	
Entertainment		Communication tools	
Home comforts		Sexual health	
Recommended web-sites		Education support	
Lead Clinician			

2. Specific Areas of Distress or Concern

In the boxes provided, please indicate which areas have been an issue for you over the past week.

Practical

- ☐ Housing or Living Arrangements
- ☐ Education
- ☐ Work or Career
- ☐ Transport or Parking
- ☐ Bills or Finances

Family

- ☐ Mum and/or Dad
- ☐ Brother(s) and/or Sister(s)
- ☐ Partner, Boyfriend or Girlfriend
- ☐ Child(ren)
- ☐ Other family members

Emotional

- ☐ Sadness
- ☐ Feeling alone or Isolated
- ☐ Anxiety or fear
- ☐ Guilt
- ☐ Boredom
- ☐ Anger or frustration
- ☐ Extreme moodiness
- ☐ Feeling hopeless or helpless
- ☐ Feeling confused
- ☐ Loss of meaning or purpose
- ☐ Loss of faith or spirituality

Social

- ☐ Isolated from friends
- ☐ Missing important events
- ☐ Friends don't understand
- ☐ Worry about partner boyfriend or girlfriend
- ☐ Missing doing the "normal stuff" with friends

Physical

- ☐ General appearance
- ☐ Hair loss
- ☐ Breathing difficulty
- ☐ Fitness or sporting ability
- ☐ Sleeping difficulty
- ☐ Constipation or Diarrhoea
- ☐ Sexual concerns
- ☐ Loss of libido (desire for sex)
- ☐ Pain when having sex
- ☐ Fertility
- ☐ Eating or appetite
- ☐ Extreme exhaustion or tiredness
- ☐ Memory or concentration
- ☐ Tingling in hands or feet
- ☐ Pain
- ☐ Nausea or vomiting
- ☐ High temperature or fever
- ☐ Use of alcohol and/or drugs
- ☐ Other medical worry

Information

- ☐ Understanding of information
- ☐ Feeling involved in decision making
- ☐ Feeling listened to (eg. by doctors, nurses, family)
- ☐ Rights to confidentiality
- ☐ Rights to privacy

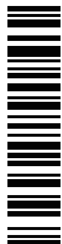
Other areas of concern not listed

I, ______________________________ understand that the above information will be used by
(Patient's name) my treating team to develop a care plan for me.

Patient Signature:	Date:
Clinician Signature:	Date:

DO NOT WRITE IN THIS BINDING MARGIN

v1.1 - 05/2014



SW541

ADOLESCENT AND YOUNG ADULT ONCOLOGY SCREENING TOOL

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URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date of Assessment		Distress Thermometer Score	
Date of Initial Care Plan		Details of Lead Clinician	
Date of Review			

Rating: L: low concern M: medium concern H: high concern *UR: urgent response

Intervention code: A: assessment R: referral I: information provided RA: risk assessment ATM: AYA team management

Issue (cross out those not indicated)	**Rating**	**Code**	**Plan** (what are we going to do)	**Contact Person** (name and number)
Practical				
Housing or Living Arrangements				
Education				
Work or Career				
Transport or Parking				
Bills or Finances				
Family				
Mum and/or Dad				
Brother(s) and/or Sister(s)				
Partner, Boyfriend or Girlfriend				
Child(ren)				
Other Family Members				
Emotional				
Sadness				
Feeling alone or isolated				
Anxiety or Fear				
Guilt				
Boredom				
Anger or Frustration				
Extreme moodiness				
Feeling hopeless or helpless				
Feeling confused				
Loss of meaning or purpose				
Loss of faith or spirituality				
Social				
Isolated from friends				
Missing important events				
Friends don’t understand				
Worry about partner, boy/girlfriend				
Missing doing “normal” stuff				
Physical				
General appearance				
Hair loss				
Breathing difficulty				
Fitness or sporting ability				
Sleeping difficulty				
Constipation or diarrhoea				
Sexual concerns				
Loss of libido (desire for sex)				
Fertility				
Eating or appetite				
Extreme exhaustion/tiredness				
Memory or concentration				
Tingling in hands or feet				
Pain				
Nausea or vomiting				
High temperature or fever				
Use of alcohol and/or drugs				
Other medical worry				

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