Room #_____

Today's Date:
___/____/_____
D M Y

CancerCare Manitoba
COMPASS
COMprehensive Problem And Symptom Screening

Place patient label here
(Must include CR)

1. Edmonton Symptom Assessment System Revised (ESAS-R)

Please circle the number that best describes how you feel <u>NOW</u>:

1.	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
2.	No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
3.	No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
4.	No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
5.	No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
6.	No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
7.	No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
8.	No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
9.	Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
10.	No _____	0	1	2	3	4	5	6	7	8	9	10	Worst Possible _____

Other problem *(for example: night sweats, wound issues)*

3. Medications

Have there been any **<u>changes</u>** since your last visit?
❒Yes (If yes, please list):

❒No **<u>change</u>** in medication

4. Other

Have you smoked in the past six weeks?
❒ Yes ❒ No

Are you interested in quitting smoking?
❒ Yes ❒ No

2. Canadian Problem Checklist

Please check all of the following items that have been a concern or problem for you in the PAST WEEK <u>INCLUDING TODAY:</u>

Physical:
- ❒ Concentration/Memory
- ❒ Sleep
- ❒ Weight
- ❒ Constipation
- ❒ Diarrhea
- ❒ Swallowing
- ❒Mouth sores
- ❒Falling/Loss of balance
- ❒Vision or hearing changes
- ❒Heartburn/Indigestion
- ❒Numbness/Tingling
- ❒Changes to skin/nails
- ❒Bleeding/Bruising
- ❒ Bladder problems

Practical:
- ❒ Work / School
- ❒ Finances
- ❒ Accommodation
- ❒Getting to and from appointments
- ❒Child/Family/Elder care
- ❒Trouble with my daily activities

Emotional:
- ❒ Fears / Worries
- ❒ Sadness
- ❒ Frustration/Anger
- ❒Changes in appearance
- ❒ Intimacy / Sexuality
- ❒ Fertility
- ❒ Coping
- ❒Loss of interest in everyday things
- ❒ Loss/grief

Dignity:
- ❒ Loss of control
- ❒ Embarrassment/shame
- ❒ Not feeling respected/understood
- ❒ Not feeling worthwhile/valued
- ❒ Feeling like I am no longer the person I once was

Spiritual:
- ❒Meaning/Purpose of life
- ❒Faith

Informational:
- ❒ Understanding my illness and/or treatment
- ❒ Talking with the health care team
- ❒ Making treatment decisions
- ❒ Knowing about available resource

Social/Family:
- ❒ Feeling a burden to others
- ❒ Worry about family/ friends
- ❒ Feeling alone
- ❒ Relationship difficulties

Advance Care Planning: *is for everyone and can be done at anytime* ❑ **Prefer not to answer**

1. Do you need information and resources on Advance Care Planning? ❑ Yes ❑ No
2. Do you want to discuss Advance Care Planning at your appointment today? ❑ Yes ❑ No
3. Has there been a change in your Advance Care Plan since your last visit? ❑ Yes ❑ No

FOR STAFF ONLY (Optional)
Assessment Notes:

Plan:

Staff name (printed)_____ Staff signature _____

Date ___/____/_____
D M Y