Concerns Checklist – identifying your concerns

Patient's name or label

Key worker:

Date:

Contact number:

This self assessment is optional. It has been designed to help us support you by identifying any concerns you may have and information you may require.

What do I need to do?

Select any areas that may have caused you concern recently and you would like to discuss with your key worker.

When selecting please score each concern between 1-10, with 1 being low level of concern and 10 the highest.

Physical concerns

- ☐ Breathing difficulties
- ☐ Passing urine
- ☐ Constipation
- ☐ Diarrhoea
- ☐ Eating, appetite or taste
- ☐ Indigestion
- ☐ Swallowing
- ☐ Cough
- ☐ Sore or dry mouth or ulcers
- ☐ Nausea or vomiting
- ☐ Tired, exhausted or fatigued
- ☐ Swelling
- ☐ High temperature or fever
- ☐ Moving around (walking)
- ☐ Tingling in hands or feet
- ☐ Pain or discomfort
- ☐ Hot flushes or sweating
- ☐ Dry, itchy or sore skin
- ☐ Changes in weight
- ☐ Wound care
- ☐ Memory or concentration
- ☐ Sight or hearing
- ☐ Speech or voice problems
- ☐ My appearance
- ☐ Sleep problems
- ☐ Sex, intimacy or fertility
- ☐ Other medical conditions

Practical concerns

- ☐ Taking care of others
- ☐ Work or education
- ☐ Money or finance
- ☐ Travel
- ☐ Housing
- ☐ Transport or parking
- ☐ Talking or being understood
- ☐ Laundry or housework
- ☐ Grocery shopping
- ☐ Washing and dressing
- ☐ Preparing meals or drinks
- ☐ Pets
- ☐ Difficulty making plans
- ☐ Smoking cessation
- ☐ Problems with alcohol or drugs
- ☐ My medication

Emotional concerns

- ☐ Uncertainty
- ☐ Loss of interest in activities
- ☐ Unable to express feelings
- ☐ Thinking about the future
- ☐ Regret about the past
- ☐ Anger or frustration
- ☐ Loneliness or isolation
- ☐ Sadness or depression
- ☐ Hopelessness
- ☐ Guilt
- ☐ Worry, fear or anxiety
- ☐ Independence

Family or relationship concerns

- ☐ Partner
- ☐ Children
- ☐ Other relatives or friends
- ☐ Person who looks after me
- ☐ Person who I look after

Spiritual concerns

- ☐ Faith or spirituality
- ☐ Meaning or purpose of life
- ☐ Feeling at odds with my culture, beliefs or values

Information or support

- ☐ Exercise and activity
- ☐ Diet and nutrition
- ☐ Complementary therapies
- ☐ Planning for my future priorities
- ☐ Making a will or legal advice
- ☐ Health and wellbeing
- ☐ Patient or carer's support group
- ☐ Managing my symptoms
- ☐ Sun protection

☐ **I have questions about my diagnosis, treatments or effects**

Key worker to complete ☐ Copy given to patient ☐ Copy to be sent to GP

WE ARE MACMILLAN. CANCER SUPPORT

Care and Support Plan

Patient's name or label

Key worker: _____

Date of Care and Support Plan: _____

Contact number: _____

Key worker to complete

☐ Copy given to patient

☐ Copy to be sent to GP

Next review date: _____

WE ARE MACMILLAN. CANCER SUPPORT

Main concerns	Plan of action
Score 1-10 (10 being highest) ☐	Patient action Key worker action
Score 1-10 (10 being highest) ☐	Patient action Key worker action
Score 1-10 (10 being highest) ☐	Patient action Key worker action