



**Remote Symptom Practice Guides
for
Adults on Cancer Treatments**

**Of the Pan-Canadian Oncology Symptom Triage and Remote Support
(COSTaRS) Team**

January 2020

Table of Contents

Copyright and Disclaimer	1
COSTaRS Steering Committee	2
Overview and Practice Guide Development	3
Example General Assessment Form	5
Practice Guides	
Anxiety.....	6
Appetite Loss	8
Bleeding	10
Breathlessness/Dyspnea	12
Constipation	14
Depression	16
Diarrhea	18
Fatigue/Tiredness	20
Febrile Neutropenia	22
Mouth Dryness/Xerostomia	24
Mouth Sores/Stomatitis	26
Nausea & Vomiting	28
Pain	30
Peripheral Neuropathy	32
Skin Rash	34
Skin Reaction	36
Sleep Changes	38
Full list of references.....	40

Copyright

Our intent is for the COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments to be used in part or as a whole as needed. Therefore, these practice guides can be reproduced without permission, although we respectfully request that you cite the resource appropriately, as follows:

Remote Symptom Practice Guides for Adults on Cancer Treatments © 2020 D Stacey for the Pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Team. University of Ottawa School of Nursing and the Ottawa Hospital Research Institute, Ottawa, Canada.

If you translate any of this material into languages other than English or French, we would appreciate that you notify Dawn Stacey RN, PhD, University of Ottawa, Ottawa, Canada.

Disclaimer

These COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments are intended for use by trained nurses. They provide general guidance on appropriate practice informed using a synthesis of clinical practice guidelines and their use is subject to the nurses' judgment in each patients' individual situation. The COSTaRS Remote Symptom Practice Guides for Adults on Cancer Treatments are designed to provide information to assist decision-making and are not meant to be prescriptive. Individuals who use these practice guides are required to make their own determination regarding specific safe and appropriate clinical practices. While care has been taken to ensure that these practice guides reflect the state of general knowledge and expert consensus about practice in the field at the date of publication, neither the COSTaRS Steering Committee nor the Canadian Partnership Against Cancer who funded the original project make any warranty or guarantee in respect to any of the content or information contained in these practice guides. Neither group accept responsibility or liability whatsoever for any errors or omissions in these practice guides, regardless of whether those errors or omissions were made negligently or otherwise.

COSTaRS Steering Committee

Current Committee Members

Chair: Dawn Stacey RN, PhD, CON(C), University of Ottawa, Ottawa, Ontario
Julie Baisley, Allan Blair Cancer Centre, Regina, Saskatchewan
Meg Carley BSc, Ottawa Hospital Research Institute, Ottawa, Ontario
Kim Chapman RN, MSc(N), Horizon Health Network, New Brunswick
Andra Davis, RN, MN, PhD, Washington State University, Vancouver, Washington
Doris Howell RN, PhD, University of Toronto, Ontario
Barb Hues RN, MSN, CON(C), Cancer Care Manitoba, Winnipeg, Manitoba
Lindsay Jibb RN, PhD, University of Toronto, Ontario
Lynne Jolicoeur RN, MScN, CON(C), The Ottawa Hospital, Ontario
Craig Kuziemsky PhD, MacEwan University, Edmonton, Alberta
Luisa Luciani Castiglia, RN, MScA, CON(C), McGill University Health Center, Montreal, Quebec
Claire Ludwig, RN, PhD(c), University of Ottawa, and Patient Advisor, Ottawa, Ontario
Gail Macartney RN(EC), PhD, ACNP, CON(C), University of Prince Edward Island, Charlottetown, PEI
Lorraine Martelli, RN(EC), MN, Cancer Care Ontario, Ontario
Katie Nichol RN, MScN, CON(C), The Ottawa Hospital, Ontario
Komal Patel RN, BScN, MN, CON(C), CHPCN(C), CVAA(C), de Souza Institute, Ontario
Amanda Ross-White BA, MLIS, Queen's University, Kingston, Ontario
Brenda Sabo RN, MA, PhD, Dalhousie University, Nova Scotia
Ann Syme RN, MSN, PhD, Langara College, Vancouver, British Columbia
Joy Tarasuk RN, BScN, CON(C), Nova Scotia Health Authority Cancer Care Program, Nova Scotia
Tracy Truant RN, MSN, PhD(c), University of British Columbia, and Patient Advisor, British Columbia
Linda Watson RN, PhD, CON(C), Cancer Control Alberta, Alberta

Immunotherapy Working Group Members

Jennifer Anderson, RN, MN, CON(C), Cancer Control Alberta, Calgary, AB
Chyanne Dey, RN, CON(C), Tom Baker Cancer Center, Calgary, AB
Carolyn Fifield BSc(Biochem), MSc(A), RN, CON(C), NSHA Cancer Care Program, NS
Pam Ginex, MPH, RN, OCN, Oncology Nursing Society, Pittsburgh, PA
Leah Jodoin MN, RN(EC), NP, CON(C) Kingston Health Sciences Centre, ON
Karey McCann RN, BScN, Cancer Control Alberta, Edmonton, AB
Kristie Morydz, NP, CancerCare Manitoba, MB
Jennifer Newton, BScN, Med, The Ottawa Hospital, ON
Cindy Railton, RN, MN, ACNP, CON(C), Tom Baker Cancer Centre, Calgary, AB

Committee Members 2012-2019

Debra Bakker RN, PhD, Laurentian University, ON	2012-2016
Barbara Ballantyne RN, MScN, CON(C), CHPCN(C), Health Sciences North, ON	2016-2019
Lorna Butler RN, PhD, University of Saskatchewan, SK	2012-2016
Dauna Crooks RN, DNSc, University of Manitoba, MB	2012-2016
Greta Cummings RN, PhD, University of Alberta, AB	2012-2019
Esther Green RN, MSc(T), Cancer Care Ontario, ON	2012-2019
Myriam Skrutkowski RN, MSc, CON(C), MUHC, QC	2012-2019
Lucie Tardif RN, M.Sc, McGill University Health Centre, QC	2016-2019
Carolyn Tayler RN, BN, MSA, CON(C), Fraser Health, BC	2012-2016

The CAN-IMPLEMENT© Team, Canadian Partnership Against Cancer, Queen's University, School of Nursing

Lead: Margaret Harrison RN, PhD	Victoria Donaldson BA
Val Angus BA	Janice McVeety RN, MHA
Meg Carley BSc	Amanda Ross-White BA, MLIS
Kirsten Dean RN, BA, BScN	Joan van den Hoek BNSc

Overview and Practice Guide Development

Management of cancer treatment-related symptoms is an important safety issue given that symptoms can become life-threatening and often occur when patients are at home. Over 50% of cancer nurses in Canada provide remote support, primarily by telephone.^{1,2} Despite that higher quality telephone services require use of symptom practice guides to minimize risk, access to symptom practice guides and their use is variable.^{1,2} With funding from the Canadian Partnership Against Cancer, in 2008 we established a pan-Canadian Steering Committee with representation from eight provinces to develop practice guides for specific common symptoms.

The practice guides were developed using a systematic process guided by CAN-IMPLEMENT[®].³⁻⁵

1. We convened a pan-Canadian Oncology Symptom Triage and Remote Support (COSTaRS) Steering Committee including researchers, an information systems researcher, library scientist, advanced practice nurses, and nurse leaders.
2. We conducted a systematic review for *each symptom* to identify clinical practice guideline(s) published in the previous 5 years. Two identified guidelines (fatigue, anxiety/depression) were developed by pan-Canadian panels using rigorous processes.^{6,7} Guidelines are syntheses of the best available evidence and are designed to support decision making in practice and health policy.⁸ However, identified clinical practice guidelines were not adequate for remote symptom support.
3. We developed 13 symptom practice guides based on the available clinical practice guidelines (median 3 guidelines per practice guide; range 1 to 7). In total, we identified > 40 practice guidelines and their quality was appraised using the AGREE instrument (range 8% to 87%).⁹ Higher rigour scores indicate higher confidence that potential biases in guideline development were addressed, and recommendations are valid (both internally and externally) and feasible for practice.¹⁰ Principles for developing the symptom practice guides included:
 - Meeting the criteria on the AGREE rigour sub-scale items (e.g. explicit recommendations, linked to evidence, based on systematic review, reviewed by experts).
 - Adding relevant questions from the valid and reliable Edmonton Symptom Assessment System (ESAS); a widely used screening instrument for routinely identifying symptoms in cancer patients seen in Canadian programs.^{11,12}
 - Enhancing usability for remote symptom support and with the potential to integrate into an electronic health record.
 - Using plain language to facilitate communication between nurses using the practice guides and patients/families (Flesch–Kincaid Grade Level 6.4).

Each symptom practice guide has five recommendations for the nurse: a) assess symptom severity; b) triage patient for symptom management based on highest severity; c) review medications being used for the symptom; d) review self-care strategies (presented using motivational interviewing techniques);¹³ and e) summarize and document the plan agreed upon with the patient.

4. We tested the practice guide usability with cancer nurses and revealed that they: are easy to read; provide just the right amount of information; use appropriate terms; are likely to fit with clinical work flow; and have excellent self-care strategies.
5. We circulated the 13 practice guides for review by cancer experts across Canada. They validated the content of the practice guides and identified the need for local adaptation to integrate the practice guides with their current approaches for handling remote symptom assessments.
6. In March 2013, practice guides were updated with evidence from systematic reviews to identify guidelines published up until the end of December 2012. We circulated the 13 updated practice guides for review by the COSTaRS committee members.
7. In January 2016, with funding from the Canadian Cancer Society (#703679), the 13 symptom practice guides were updated with evidence from systematic reviews to identify guidelines published up to August 2015. As well, new practice guides for pain and sleep changes were added. AGREE Rigour Scores for source guidelines were removed given inconsistent reporting.

Evidence ratings were changed to indicate how well the medications work (e.g. effective, likely effective, or expert opinion). The 15 practice guides were reviewed by the current COSTaRS committee members and a summary of changes for the 2016 update are available at <http://www.canadianoncologynursingjournal.com/index.php/conj/article/view/764>.

8. In January 2020, the 15 symptom practice guides were updated with evidence using systematic review methods described previously and new practice guides for Mouth Dryness/Xerostomia and Skin Rash were added. At the COSTaRS priority setting meeting in 2017, adding evidence for patients receiving Immune Checkpoint Inhibitor therapy into the practice guides was identified as high priority given the increased use of immunotherapy and the special considerations required for managing treatment related symptoms. Key assessment and self-care items for patients receiving immunotherapy were added. End-users asked how severity assessment correlated with the NCI-CTCAE grading that they use in their assessments, clinical documentation and communications with physicians therefore NCI-CTCAE grading has been linked to applicable assessment questions in the practice guides.

In summary, we have developed 17 user-friendly remote symptom practice guides based on a synthesis of the best available evidence, validated the practice guides with oncology nurses, and used plain language to facilitate use with patients. Now they are available to be used in routine remote support practices.

References:

- (1) Stacey D, Bakker D, Green E, Zanchetta M, Conlon M. Ambulatory oncology nursing telephone services: A provincial survey. *Canadian Oncology Nursing Journal* 2007;17(4):1-5.
- (2) Macartney G, Stacey D, Carley M, Harrison M. Priorities, Barriers and Facilitators for Remote Support of Cancer Symptoms: A Survey of Canadian Oncology Nurses. *Canadian Oncology Nursing Journal* 2012;22(4):235-240. Priorités, obstacles et facilitateurs concernant le traitement à distance des symptômes du cancer: enquête après des infirmières en oncologie du Canada. P 241-47.
- (3) Harrison MB, Legare F, Graham ID, Fervers B. Adapting clinical practice guidelines to local context and assessing barriers to their use. *Canadian Medical Association Journal* 2010;182(2):E78-E84.
- (4) Harrison MB, van den Hoek J, for the Canadian Guideline Adaptation Study Group. CAN-IMPLEMENT©: A Guideline Adaptation and Implementation Planning Resource. Kingston, Ontario: Queen's University School of Nursing and Canadian Partnership Against Cancer; 2012.
- (5) Stacey D, Macartney G, Carley M, Harrison MB, COSTaRS. Development and evaluation of evidence-informed clinical nursing protocols for remote assessment, triage and support of cancer treatment-induced symptoms. *Nurs Res Pract* 2013;2013:171872.
- (6) Howell D, Currie S, Mayo S et al. A Pan-Canadian Clinical Practice Guideline: Assessment of Psychosocial Health Care Needs of the Adult Cancer Patient. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology; 2009.
- (7) Howell D, Keller-Olaman S, Oliver TK et al. A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Cancer-Related Fatigue in Adults with Cancer. Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology; 2011.
- (8) Gagliardi AR, Brouwers MC, Palda VA, Lemieux-Charles L, Grimshaw JM. How can we improve guideline use? A conceptual framework of implementability. *Implementation Science* 2011;6(26):1-11.
- (9) The AGREE Collaboration. Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument. www.agreecollaboration.org; 2001.
- (10) Brouwers M, Kho ME, Browman GP et al. Development of the AGREE II, part 2: assessment of validity of items and tools to support application. *Canadian Medical Association Journal* 2010;182(10):E472-E478.
- (11) Barbera L, Seow H, Howell D et al. Symptom burden and performance status in a population-based cohort of ambulatory cancer patients. *Cancer* 2010;116(24):5767-5776.
- (12) Nekolaichuk C, Watanabe S, Beaumont C. The Edmonton Symptom Assessment System: a 15-year retrospective review of validation studies (1991-2006). *Palliative Medicine* 2008;22(2):111-122.
- (13) Miller WR, Rollnick S. *Motivational interviewing: Preparing people for change (2nd ed.)*. New York: Guilford Press; 2002.

Example General Assessment Form

Practice Guides for the Remote Assessment, Triage, and Self-care of Symptoms in Adults Undergoing Cancer Treatment

Date and time of encounter _____ Type of encounter (phone/in-person) _____

Type of Cancer(s) _____ Primary Oncologist _____

Other practitioners (most responsible) _____

1. Which symptom(s)

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Mouth sores/Stomatitis | <input type="checkbox"/> Skin Reaction to radiation |
| <input type="checkbox"/> Appetite Loss | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Nausea & Vomiting | <input type="checkbox"/> Sleep changes |
| <input type="checkbox"/> Bleeding | <input type="checkbox"/> Fatigue/Tiredness | <input type="checkbox"/> Pain | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Breathlessness | <input type="checkbox"/> Febrile Neutropenia | <input type="checkbox"/> Peripheral Neuropathy | _____ |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Mouth dryness/Xerostomia | <input type="checkbox"/> Skin Rash | _____ |

2. Tell me about your symptom(s) (Supporting Evidence: Expert Consensus)

(PQRST- Provoking factors, Quality, Radiating, Relieving factors, Severity, Other symptoms, Timing, Triggers, Location)

3. Conduct general symptom assessment (Supporting Evidence: Expert Consensus)

Receiving cancer treatment:

Radiation: Site of radiation _____

Chemotherapy: Name of Chemotherapy _____

Immune Checkpoint Inhibitor Therapy: Name of Immune Checkpoint Inhibitor _____

Other systemic therapy (e.g. antiestrogen, monoclonal antibodies, targeted therapies): Name of therapy: _____

Surgery: _____

Date of last treatment(s) _____

Length of time since symptom started? _____

New symptom? Yes No Unsure

Told symptom could occur? Yes No Unsure

Other symptoms? Yes No If Yes, specify _____

Recent exposure to known virus/flu? Yes No Unsure If Yes, specify _____

4. Assess current use of medications, herbs, natural health products (name, dose, current use)

Medication	Dose Prescribed	Taking as prescribed/Last dose if PRN
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No /

Are any medications new or are there recent changes? Yes No If Yes, specify: _____




5. See relevant symptom practice guide(s) for further assessment, triage and self-care.

Anxiety Practice Guide

Anxiety: an emotional or physiologic response to known or unknown causes that ranges from a normal reaction to extreme dysfunction. It may impact on decision making, adherence to treatment, functioning, or quality of life; nervousness; concern; feeling of worry; apprehension.¹⁻³

1. Assess severity of the anxiety (Supporting evidence: 10 guidelines)¹⁻¹⁰

Tell me what number from 0 to 10 best describes how anxious you are feeling (0= “no anxiety”; 10= “worst possible anxiety”) ^{1,3,4,11}	1 – 3	<input type="checkbox"/>	4 - 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Are you having panic attacks: <input type="checkbox"/> periods/spells of sudden fear, <input type="checkbox"/> discomfort, <input type="checkbox"/> intense worry, <input type="checkbox"/> uneasiness? ¹⁻⁴	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Does your anxiety affect your daily activities? ^{1-4,12}	Not at all ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Does your anxiety affect your sleep? ¹⁻⁴	Not at all	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do any of these apply to you? ¹⁻⁴ <input type="checkbox"/> Female, <input type="checkbox"/> Waiting for test results, <input type="checkbox"/> Financial problems, <input type="checkbox"/> History of anxiety or depression, <input type="checkbox"/> Younger age (<30), <input type="checkbox"/> Lack of social support, <input type="checkbox"/> Alcohol/ substance use/withdrawal, <input type="checkbox"/> Not exercising, <input type="checkbox"/> Dependent children <input type="checkbox"/> Recurrent/advanced disease, <input type="checkbox"/> On steroids, <input type="checkbox"/> Recently completed treatment	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Do have any concerns that are making you feel more anxious: ¹⁻⁴ <input type="checkbox"/> life events, <input type="checkbox"/> new information about cancer/treatment, <input type="checkbox"/> spiritual/ religious concerns?	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>		
Do you have any other symptoms? ¹⁻⁴ <input type="checkbox"/> Fatigue, <input type="checkbox"/> Breathlessness, <input type="checkbox"/> Pain, <input type="checkbox"/> Sleep changes	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of hyperthyroidism): ⁵⁻¹⁰ <input type="checkbox"/> weight loss, <input type="checkbox"/> heart pounding or racing, <input type="checkbox"/> tremors, <input type="checkbox"/> feeling overheated, <input type="checkbox"/> diarrhea	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others? ^{1,3,4}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>

	 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 4 guidelines)¹⁻⁴	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days	<input type="checkbox"/> If potential for harm, refer for further evaluation immediately <input type="checkbox"/> If no, refer for non-urgent medical attention <input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications <input type="checkbox"/> Alert clinician if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for anxiety, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 4 guidelines)¹⁻⁴

Current use	Examples of medications for anxiety*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzodiazepines - lorazepam (Ativan [®]), diazepam, (Valium [®]), alprazolam (Xanax [®]) ¹⁻⁴		Likely effective
<input type="checkbox"/>	SSRIs - fluoxetine (Prozac [®]), sertraline (Zoloft [®]), paroxetine (Paxil [®]), citalopram (Celexa [®]), fluvoxamine (Luvox [®]), escitalopram (Lexapro [®]) ^{1,3,4}		Expert opinion

*Use of medications should be based on severity of anxiety and potential for interaction with other medications.^{1,4} Benzodiazepines are intended for short term use. Caution: may cause confusion, ataxia and falls in the elderly.^{1,4}

4. Review 3 or more self-care strategies (Supporting evidence: 5 guidelines)^{1-4,13}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing when you feel anxious?
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel anxious? Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you shared your concerns and worries with your health provider? ²⁻⁴
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What are you doing for physical activity including yoga? ¹⁻³
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in any support groups and/or have family/friends you can rely on for support? ¹⁻⁴
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation therapy , yoga, breathing techniques, listening to music, guided imagery? ^{1-4,13}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried massage therapy with or without aromatherapy? ¹⁻³
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive-behavioural therapy , mindfulness-based stress reduction, or received personal counseling that provides more in-depth guidance on managing anxiety and problem solving? ¹⁻⁴
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If your concerns are spiritual or religious in nature, have you tried spiritual counseling, meaning-focused meditation, prayer, worship, or other spiritual activities ? ^{2,3}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms, cancer or your treatment help to ease your worries? If yes, provide relevant information or suggest resources. ¹⁻⁴

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur
Name	
Signature	
Date	




References: 1) Howell 2015; 2) ONS 2017; 3) NCCN 2018; 4) Butow 2015; 5) Puzanov 2017; 6) Hryniewicki 2018; 7) BCCA 2017; 8) Brahmer 2018; 9) CCO 2018; 10) Haanen 2017; 11) Watanabe 2011; 12) NIH-NCI CTCAE 2017; 13) Bradt 2016 (see pages 40-48 for full references)

Appetite Loss Practice Guide

Anorexia: An involuntary loss of appetite;¹⁻³ being without hunger.

1. Assess severity of the appetite loss (Supporting evidence: 8 guidelines)¹⁻⁸

Tell me what number from 0 to 10 best describes your appetite (0= “best appetite” and 10= “Worst possible lack of appetite”) ^{2-4,9}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your lack of appetite? ¹⁻⁴	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How much have you eaten in the past 24 hours (e.g. at each meal)? ^{2-4,10}	Less than normal ^{G1}	<input type="checkbox"/>	Much less than normal ^{G2}	<input type="checkbox"/>	Not eating at all ^{G≥3}	<input type="checkbox"/>
Have you lost weight in the last 4 weeks without trying? ¹⁻⁴ Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
How much fluid are you drinking per day? ^{2,3}	6-8 glasses	<input type="checkbox"/>	1-5 glasses	<input type="checkbox"/>	Sips	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{2-4,10}	No ^{G0}	<input type="checkbox"/>	Yes, some ^{G1}	<input type="checkbox"/>	Yes, a lot ^{G≥2}	<input type="checkbox"/>
Is there anything causing your lack of appetite: ¹⁻⁴ <input type="checkbox"/> Recent surgery/treatment, <input type="checkbox"/> New medication, <input type="checkbox"/> Other	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Do you have any other symptoms? ¹⁻⁴ <input type="checkbox"/> Sore mouth, <input type="checkbox"/> Early fullness, <input type="checkbox"/> Taste/smell changes, <input type="checkbox"/> Nausea/ vomiting, <input type="checkbox"/> Swallowing problems, <input type="checkbox"/> Pain, <input type="checkbox"/> Constipation, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Depression, <input type="checkbox"/> Breathlessness	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ⁵⁻⁸ <input type="checkbox"/> fatigue, <input type="checkbox"/> headache, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin, <input type="checkbox"/> hair loss, <input type="checkbox"/> puffy face, <input type="checkbox"/> constipation, <input type="checkbox"/> nausea, <input type="checkbox"/> fever	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of renal toxicity): ⁸ <input type="checkbox"/> decreased urine, <input type="checkbox"/> blood in urine, <input type="checkbox"/> swelling of hands or legs	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your poor appetite affect your daily activities? ¹⁻⁴	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>

	 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)^{2,3}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> If severe loss of appetite is stabilized, review self-care strategies <input type="checkbox"/> If severe loss of appetite is new refer for medical attention immediately. <input type="checkbox"/> Alert clinician if on immunotherapy.

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for appetite loss, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 4 guidelines)¹⁻⁴

Current use	Examples of medications for appetite*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Megestrol (Megace®) ¹⁻⁴		Effective
<input type="checkbox"/>	Corticosteroids - dexamethasone (Decadron®), prednisone ¹⁻⁴		Effective
<input type="checkbox"/>	Omega 3 fatty acids (EPA, Fish Oil) ^{3,4}		Expert Opinion
<input type="checkbox"/>	Prokinetics (metoclopramide, domperidone) for early satiety and nausea ²⁻⁴		Expert Opinion

* Megestrol has potential for serious side effects such as blood clot.⁴ Corticosteroids offer short-lived benefit; long-term use is associated with significant toxicities.^{1,3,4} Cannabis/Cannabinoids are not recommended.^{1,3,4}

4. Review 3 or more self-care strategies (Supporting evidence: 4 guidelines)¹⁻⁴

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for improving your appetite? ^{2,3}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel like you are not hungry? ^{2,3} Reinforce as appropriate.
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat 5-6 small meals ? ²⁻⁴ Sitting upright for 30-60 min helps digestion. ³
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If food odours bother you, have you tried eating foods that are cold, with less odour , or avoiding being in the kitchen during meal preparation? ³
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat more when you feel most hungry ? ³
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat foods that are higher in protein and calories ? ²⁻⁴
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have beliefs about certain foods (e.g. cultural or think some foods cause cancer) or pre-existing diet (e.g. diabetes) that may affect your eating habits? ¹⁻⁴
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you able to obtain groceries and prepare meals (access to food, financial resources)? If not, suggest buying convenience foods or asking friends/family for help. ^{2,3}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you drinking higher energy and protein drinks (Ensure, Glucerna)? ¹⁻⁴
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you staying as active as possible? ²⁻⁴ (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week)
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a diary to track your food, fluid intake and weight? ²⁻⁴
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If your food intake has been very low for a long time, are you slowly increasing your intake over several days (to prevent refeeding syndrome)? ^{3,4}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a dietitian? ¹⁻⁴ If you are having taste changes, they can suggest ways to help lessen your symptoms.
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? ^{2,3} If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------




References: 1) ONS 2017; 2) CCO 2012; 3) BCCA 2014; 4) Arends 2017; 5) CCO 2018; 6) Haanen 2017; 7) NCCN 2018; 8) Puzanov 2017; 9) Watanabe 2011; 10) NIH-NCI CTCAE 2017 (see pages 40-48 for full references)

Bleeding Practice Guide

Bleeding: Loss of blood, bruising or petechiae that may be the result of a reduction in the quantity or functional quality of platelets, wound or ulcer, an alteration of clotting factors, a paraneoplastic syndrome, or a combination of these.¹

1. Assess severity of the bleeding (Supporting evidence: 9 guidelines)¹⁻⁹

Where are you bleeding from?^{1,2} _____

How much blood loss? ^{1,2}	Minor (e.g. 1 tsp)	<input type="checkbox"/>	Some (e.g. 1 tbsp)	<input type="checkbox"/>	Gross (e.g. ¼ cup)	<input type="checkbox"/>
Are you worried about your bleeding? ²	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have any new bruises? ¹	No	<input type="checkbox"/>	Few	<input type="checkbox"/>	Generalized	<input type="checkbox"/>
→ Bruising or bleeding more easily than normal? ³	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you had problems with blood clotting (e.g. >10-15min)? ¹⁻⁶	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ^{3-6,8,9}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have any blood in your: <input type="checkbox"/> stool or is it black/tarry? ¹⁻⁹ <input type="checkbox"/> urine? ¹⁻³ <input type="checkbox"/> vomit or does it look like coffee grounds? ¹ <input type="checkbox"/> phlegm/sputum when you cough? ^{1,2} <input type="checkbox"/> nose and mouth? ³ <input type="checkbox"/> other	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
If you are having menstrual periods has there been an increase bleeding? ^{1,2}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Do you have (signs of hematological adverse effects): <input type="checkbox"/> weak, <input type="checkbox"/> pale, <input type="checkbox"/> yellow skin/eyes ³⁻⁶	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you know what your last platelet count was? ^{1-3,5,7} Date:	≥ 100	<input type="checkbox"/>	20-99	<input type="checkbox"/>	< 20	<input type="checkbox"/>
→ Results of your last liver function blood test? ³⁻⁸	AST/ALT: Total bilirubin:	≤ 3x ULN ≤1.5x ULN	>3-5x ULN 1.5-3x ULN	<input type="checkbox"/>	> 5x ULN > 3x ULN	<input type="checkbox"/>
Are you taking medicines that increase risk of bleeding? ² (e.g., NSAIDs, acetylsalicylic acid, warfarin, heparin, dalteparin, tinzaparin, apixaban enoxaparin, herbal). If warfarin: do you know your last INR blood count ^{1,2} Date:	No	<input type="checkbox"/>	Yes, acetylsalicylic acid	<input type="checkbox"/>	Yes, other blood thinners	<input type="checkbox"/>
		Mild (Green)		Moderate (Yellow)		Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 8 guidelines)^{1,3-9}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately. <input type="checkbox"/> Alert clinician if on immunotherapy.			

Legend: → Immune Checkpoint Inhibitor therapy

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications/treatment patient is using for bleeding, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 9 guidelines)^{1,3-10}

Current use	Examples of medications for bleeding	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Platelet transfusion for thrombocytopenia ^{1,3-5,10}		Effective
<input type="checkbox"/>	Mesna oral or IV to prevent cystitis with bleeding ^{1,2}		Likely effective
<input type="checkbox"/>	Tranexamic acid (Cyklokapron®) ¹		Likely effective
<input type="checkbox"/>	Pantoprazole IV (Panto IV®) for GI bleeding ²		Expert opinion
<input type="checkbox"/>	Octreotide IV (Sandostatin®) for GI bleeding ²		Expert opinion
<input type="checkbox"/>	→ Corticosteroids/prednisone ³⁻⁹		Expert opinion
<input type="checkbox"/>	→ Factor replacement for acquired hemophilia ³		Expert opinion
<input type="checkbox"/>	→ Eculizumab for hemolytic uremic syndrome ³		Expert opinion

Legend: → Immune Checkpoint Inhibitor therapy

4. Review 3 or more self-care strategies (Supporting evidence: 3 guidelines)¹⁻³

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to apply direct pressure for 10-15 minutes when the bleeding occurs? ¹
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use ice packs ? ¹
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a dressing, is there bleeding when it is changed? If yes, do you try to minimize how often the dressing is done , and use saline to help remove the dressing? ¹
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using any special dressings to control bleeding of a wound (e.g. non-stick gauze, medicated dressing, packing)? ¹
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a pharmacist or clinician about medications you are taking that may affect bleeding ? ¹⁻³
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. ¹

5. Summarize and document plan agreed upon with patient (check all that apply)




<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify: _____
<input type="checkbox"/>	Referral (service & date): _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur
Name _____	
Signature _____	
Date _____	

References: 1) ONS 2019; 2) CCNS 2014; 3) Brahmer 2018; 4) CCO 2018; 5) Puzanov 2017; 6) Hryniewicki 2018; 7) Haanen 2017; 8) NCCN 2018; 9) BCCA 2017; 10) Estcourt 2012 (see pages 40-48 for full references)

Breathlessness/Dyspnea Practice Guide

Breathlessness/Dyspnea: A subjective experience described as breathing discomfort of varying intensities (e.g. hard to breathe, feeling smothered, tightness in chest, unable to catch breath, panting, gasping).¹⁻³

1. Assess severity of the breathlessness (Supporting evidence: 13 guidelines)¹⁻¹³

What number from 0 to 10 best describes your shortness of breath (0= "no shortness of breath"; 10= "Worst possible shortness of breath"? ^{2,3,14}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your shortness of breath? ¹⁻³	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you pause while talking every 5-15 seconds? ^{2,3}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is your breathing noisy, rattily or congested? ^{2,3}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a new cough or wheezing? ^{3-5,7}	No	<input type="checkbox"/>	Yes (dry)	<input type="checkbox"/>	Yes (wet)	<input type="checkbox"/>
→Do you have (signs of pneumonitis): cough, wheezing, chest pain, fever, fatigue ^{1,8-13}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you wake suddenly short of breath? ^{2,3,5,7}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ^{2,3} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you know your last red blood cell count? ^{3,15}	≥100 ^{G1}	<input type="checkbox"/>	80-99 ^{G2}	<input type="checkbox"/>	<80 ^{G3}	<input type="checkbox"/>
Do you have new pale skin or bluish colour in your nail beds? ^{2,3}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have chest pain? ^{2,3}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
♥ Does it go away with: <input type="checkbox"/> Rest or <input type="checkbox"/> Medication? ⁴	Yes	<input type="checkbox"/>			No	<input type="checkbox"/>
What activity level are you short of breath? ^{2,3,5-7,15}	Moderate ^{G1}	<input type="checkbox"/>	Mild ^{G2}	<input type="checkbox"/>	At rest ^{G≥3}	<input type="checkbox"/>
Do you have any other symptoms? ^{1-4,7} <input type="checkbox"/> Fatigue, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Depression, <input type="checkbox"/> Pain	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
♥ Have you gained or lost weight in the last week? ³⁻⁷ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	≥4lbs in 2 days; 5lbs in 1 week	<input type="checkbox"/>	≥5lbs in 2 days	<input type="checkbox"/>
Have you raised the head of your bed or increased the number of pillows you need to sleep? ^{3-5,7}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Need to sleep in a chair	<input type="checkbox"/>
Do you have swelling in your hands, ankles, feet, legs or stomach? ^{3-5,7}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have a fast heartbeat that does not slow down when you rest? ^{3-5,7}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→Do you have (signs of cardiovascular toxicity): <input type="checkbox"/> irregular heartbeat (e.g. too hard or too fast, skipping a beat, fluttering), <input type="checkbox"/> fatigue ^{8,10,11}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your shortness of breath affect your daily activities? ^{3,4}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
	 1	Mild (Green)	 2	Moderate (Yellow)	 3	Severe (Red)
2. Triage for symptom management based on highest severity (Supporting evidence: 9 guidelines)^{2-4,8-13}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		<input type="checkbox"/> Refer for medical attention immediately. <input type="checkbox"/> Alert clinician if on immunotherapy	

Legend: → Immune Checkpoint Inhibitor therapy; ♥ Cardiology; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3+

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications for shortness of breath, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 14 guidelines)^{1-6,8-13,16,17}

Current use	Examples of medications for shortness of breath*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Immediate-release oral or parenteral opioids ^{1-3,5}		Effective
<input type="checkbox"/>	Non-invasive ventilation (CPAP mask) ^{1,2}		Likely effective
<input type="checkbox"/>	Oxygen for hypoxic patients ^{2,3}		Expert Opinion
<input type="checkbox"/>	Bronchodilators ³		Expert Opinion
<input type="checkbox"/>	♥ Diuretics ^{3-6,16,17}		Effective
<input type="checkbox"/>	♥ Nitrates ^{16,17}		Benefits Balanced with Harm
<input type="checkbox"/>	→ Corticosteroids, infliximab, mycophenolate mofetil, or cyclophosphamide for pneumonitis ⁸⁻¹³		Expert Opinion

*Palliative oxygen is not recommended;^{1,3,5,6,17} Other medications may be prescribed for heart failure^{4-7,16-18}

4. Review 3 or more self-care strategies (Supporting evidence: 8 guidelines)^{1-7,16}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your comfort goal or acceptable level for this symptom? ¹⁻³
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you are short of breath? ^{2,3} Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a fan, open window , or humidifier to increase air flow to your face? ^{2,3}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried to turn down the temperature in your house? ¹⁻³
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to rest in upright positions that can help you breath? ¹⁻³
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying different relaxation and breathing exercises (e.g. pursed lip breathing)? ¹⁻³
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to conserve your energy (e.g. balance activity with rest) or use assistive devices (e.g. wheelchair) to help with activities that cause your shortness of breath? ¹⁻³
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When breathing is stable, have you tried physical activity (e.g. walking 15-30 min) at least twice a week? ^{2-4,7,16}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have difficulty eating, are you taking nutrition supplements ¹
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ Do you weigh yourself daily (after waking & voiding, before dressing and eating)? ³⁻⁷
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ Have you tried limiting your salt intake to under 1/2 tsp (< 2000mg) per day? ^{4,6,7,16}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ Are you trying to drink fluids, 6-8 glasses per day? ^{4,6,7,16}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	♥ If you drink >1-2 alcohol drinks/day, have you tried to reduce to 1 drink/day ? ^{4,5,7,16}
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you smoke, have you tried to stop? ^{3-5,7,16}
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive behavioural therapy (relaxation therapy, guided imagery) or supportive counselling ? ¹⁻³
16. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. ^{1,2}

5. Summarize and document plan agreed upon with patient (check all that apply)




<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____	
<input type="checkbox"/>	Referral (service & date): _____	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____	
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date

References: 1) ONS 2017; 2) CCO 2010; 3) BCCA 2014; 4) BC Guidelines 2015; 5) SIGN 2016; 6) ACCF/AHA 2013; 7) ESC 2016; 8) Brahmer 2018; 9) NCCN 2018; 10) Puzanov 2017; 11) Haanen 2017; 12) Hryniewicki; 13) CCO 2018; 14) Watanabe 2011; 15) NCI-CTCAE 2017; 16) CCS 2012; 17) NHF 2011; 18) ACC/AHA/HFSA 2016 (see pages 40-48 for full references)

Constipation Practice Guide

Constipation: A decrease in the frequency or passage of stool usually characterized by stools that are hard.¹⁻³

1. Assess severity of the constipation (Supporting evidence: 9 guidelines)¹⁻⁹

Are you worried about your constipation? ^{2,3}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How many days has it been since you had a bowel movement (compared to normal)? ¹⁻³	≤ 2 days	<input type="checkbox"/>	≥3 days	<input type="checkbox"/>	≥3 days on meds	<input type="checkbox"/>
How would you describe your stools (colour, hardness, odour, amount, blood, straining)? ¹⁻³					Blood in stool	<input type="checkbox"/>
Do you have hemorrhoids? ^{2,3}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have any pain in your abdomen? ¹⁻³	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you have loss of bladder or bowel control, numbness in your fingers, toes or buttocks, feel unsteady on your feet, or difficulty walking? ¹⁻³	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your abdomen feel bloated? ¹⁻³ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have lots of gas? ^{2,3}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does it feel like your rectum is not emptying after a bowel movement, or diarrhea (possible overflow around blocked stool)? ¹⁻³	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Have you recently had abdominal surgery? ^{1,3}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ³ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ¹⁻³	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have any other symptoms? ¹⁻³ <input type="checkbox"/> Appetite loss, <input type="checkbox"/> Nausea/vomiting	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of hypothyroidism): ^{4-6,8,9} <input type="checkbox"/> weight gain, <input type="checkbox"/> fatigue, <input type="checkbox"/> depression, <input type="checkbox"/> feeling cold, <input type="checkbox"/> headaches, <input type="checkbox"/> deeper voice, <input type="checkbox"/> hair loss	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of autonomic neuropathy): ⁵ <input type="checkbox"/> nausea, <input type="checkbox"/> urinary problems, <input type="checkbox"/> sweating changes	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you taking medications that cause constipation? ¹⁻³	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does your constipation affect your daily activities? ^{2,3,10}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
		Mild (Green)		Moderate (Yellow)		Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guideline)³	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours		<input type="checkbox"/> Refer for medical attention immediately <input type="checkbox"/> Alert clinician if on immunotherapy	

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for constipation, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)¹⁻³

Current use	Examples of medications for constipation*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Oral sennosides (Senokot®) ¹⁻³		Likely effective
<input type="checkbox"/>	Polyethylene glycol (PEG; RestoaLAX®, Lax-a-day®) ¹⁻³		Likely effective
<input type="checkbox"/>	Bisacodyl (Dulcolax®) and/or lactulose ^{2,3}		Expert Opinion
<input type="checkbox"/>	Suppositories** (Dulcolax®/bisacodyl, glycerin) or Enema ^{2,3}		Expert Opinion
<input type="checkbox"/>	Picosulfate sodium-magnesium oxide-citric acid ²		Expert Opinion
<input type="checkbox"/>	Methylnaltrexone injection for opioid as cause ¹⁻³		Effective
<input type="checkbox"/>	Sorbitol ^{2,3}		Expert Opinion
<input type="checkbox"/>	Amidotrizoate (Gastrografin®) if laxative resistant/advanced cancer ¹		Likely effective

*If opioid-induced constipation, fentanyl and oxycodone+naloxone have less constipation;^{1,3} Docusate sodium (Colace®) was removed due to lack of evidence for its efficacy; Avoid non-sterilized corn syrup (can be a source of infection) and castor oil (can cause severe cramping)¹ **Verify blood count before using suppositories.

4. Review 3 or more self-care strategies (Supporting evidence: 3 guidelines)¹⁻³

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your constipation? ^{2,3}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you are constipated? ^{2,3} Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What is your normal bowel routine ? ¹⁻³ Reinforce as appropriate. Specify:
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use the toilet 30-60 minutes after meals ? ¹⁻³
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink fluids, 6-8 glasses per day , especially warm or hot fluids? ¹⁻³ Are you trying to limit your intake of caffeine or alcohol? ^{2,3}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you slowly increased the fiber in your diet to 25g/day? (Only appropriate if adequate fluid intake (1500ml/24 hrs) and physical activity) ^{2,3}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you eat fruit that are laxatives ? (pitted dates, prunes, prune nectar, figs) ^{2,3}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you staying as active as possible? (e.g. walking 15-20 minutes 1-2x/day; 30-60 minutes 3-5x/week) ^{2,3}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have easy access to a private toilet or bedside commode? ¹⁻³ If possible, it is best to avoid a bedpan. ¹
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have a low neutrophil count are you avoiding rectal exams, suppositories, enemas ? ¹⁻³
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a clinician or pharmacist or dietitian about the constipation? ¹⁻³
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. ^{2,3}

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:	
<input type="checkbox"/>	Referral (service & date):	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:	
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date

References: 1) ONS 2017; 2) CCO 2012; 3) BCCA 2014; 4) Puzanov 2017; 5) Brahmer 2018; 6) Hryniewicki 2018; 7) NCCN 2018; 8) BCCA 2017; 9) CCO 2018; 10) Watanabe 2011; 11) NCI-CTCAE 2017 (see pages 40-48 for full references)




Depression Practice Guide

Depression: a range of feelings and emotions from normal sadness to chronic, depressed emotional affect, feelings of despair, irritable mood, hopelessness.^{1,2}

1. Assess severity of the depression (Supporting evidence: 8 guidelines)¹⁻⁸

Are you currently receiving professional care for depression?⁴ Yes No Specify: _____

What number from 0 to 10 best describes how depressed you are feeling where 0="no depression" and 10="worst possible depression" ^{2-6,9}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Have you felt depressed or had a loss of pleasure for 2 weeks or longer? ¹⁻⁵	No	<input type="checkbox"/>	Yes, off/on	<input type="checkbox"/>	Yes, constant	<input type="checkbox"/>
Do you feel down or depressed most of the day? ⁴	No	<input type="checkbox"/>	Yes, off/on	<input type="checkbox"/>	Yes, every day	<input type="checkbox"/>
Have you experienced any of the following for ≥ 2 weeks: <input type="checkbox"/> feeling worthless, <input type="checkbox"/> sleeping too little or too much, <input type="checkbox"/> feeling guilty, <input type="checkbox"/> weight gain or weight loss <input type="checkbox"/> unable to think or concentrate? ^{1-3,5}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Does feeling depressed affect your daily activities? ^{1-6,10}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Have you felt tired or fatigued? ^{1-3,5} (ESAS-r fatigue rating)	No, 1-3	<input type="checkbox"/>	Yes, 4-6	<input type="checkbox"/>	Yes, 7-10	<input type="checkbox"/>
Have you felt agitated (may include twitching or pacing), confused, or slowing down of your thoughts? ^{1-3,5}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>
Do any of these apply to you? <input type="checkbox"/> younger age (< 30), <input type="checkbox"/> female, <input type="checkbox"/> lack of social support, <input type="checkbox"/> prior depression, <input type="checkbox"/> financial problems, <input type="checkbox"/> prior abuse, <input type="checkbox"/> alcohol/ substance use/withdrawal, <input type="checkbox"/> dependent children, <input type="checkbox"/> chronic/ advanced disease, <input type="checkbox"/> recently completed treatment? ¹⁻⁶	None	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do have any concerns that are making you feel more depressed: ¹⁻⁶ <input type="checkbox"/> life events, <input type="checkbox"/> new information about cancer/treatment, <input type="checkbox"/> spiritual/ religious concerns?	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>		
Do you have any other symptoms? ¹⁻⁵ <input type="checkbox"/> Fatigue, <input type="checkbox"/> Pain, <input type="checkbox"/> Sleep changes, <input type="checkbox"/> Anxiety	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→Do you have (signs of hyperthyroidism): <input type="checkbox"/> weight loss, <input type="checkbox"/> heart pounding or racing, <input type="checkbox"/> tremors, <input type="checkbox"/> feeling overheated, <input type="checkbox"/> diarrhea ^{7,8}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you had recurring thoughts of dying, trying to kill yourself or harming yourself or others? ¹⁻⁶	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>

	1	Mild (Green)		2	Moderate (Yellow)		3	Severe (Red)
---	----------	------------------------	---	----------	-----------------------------	---	----------	------------------------

2. Triage patient for symptom management based on highest severity (Supporting evidence: 6 guidelines)¹⁻⁶

<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days	<input type="checkbox"/> If potential for harm, refer for further evaluation immediately <input type="checkbox"/> If no, refer for non-urgent medical attention <input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Alert clinician if on immunotherapy
--	---	--

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for depression, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 5 guidelines)^{1-3,5,6}

Current use	Examples of medications for depression*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	SSRIs - fluoxetine (Prozac [®]), sertraline (Zoloft [®]), paroxetine (Paxil [®]), citalopram (Celexa [®]), fluvoxamine (Luvox [®]), escitalopram (Lexapro [®]) ^{1-3,5,6}		Effective
<input type="checkbox"/>	Tricyclic antidepressants - amitriptyline (Elavil [®]), imipramine (Tofranil [®]), desipramine (Norpramin [®]), nortriptyline (Pamelor [®]), doxepin (Sinequan [®]) ^{1,2,5,6}		Effective
<input type="checkbox"/>	SNRIs - venlafaxine (Effexor XR [®]), duloxetine (Cymbalta [®]) ¹		Effective
<input type="checkbox"/>	Psychostimulants - methylphenidate (Ritalin [®]) ^{1,2}		Effective
<input type="checkbox"/>	Other antidepressants - bupropion (Wellbutrin [®]), trazodone (Mylan [®]), mirtazapine (Remeron [®]), Mianserina (Tolvon [®]) ¹		Effective

*Antidepressant medication is effective for major depression but use depends on side effect profiles of medications and the potential for interaction with other medications.^{1-3,5,6}

4. Review 3 or more self-care strategies (Supporting evidence: 6 guidelines)¹⁻⁶

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
			1. What is your goal for feeling less depressed?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. What helps when you feel depressed? Reinforce as appropriate. Specify:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. What are you doing for physical activity ? ^{2-4,6}
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. Do you feel you have enough help at home and with getting to appointments/treatments (transportation, financial assistance, medications)? ^{2-4,6}
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5. Do you take part in any support groups and/or have family/friends you can rely on for support? ¹⁻⁶
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6. Have you tried relaxation therapy or guided imagery, ^{1-3,5} or creative therapies (e.g. art, dance, music)? ^{2,3}
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7. Have you tried a program such as cognitive-behavioural therapy , mindfulness-based stress reduction or received personal or couple counseling that provides more in-depth guidance on managing depression? ¹⁻⁶
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8. If your concerns are spiritual or religious in nature, have you tried spiritual counseling, meaning-focused meditation, prayer, worship, or other spiritual activities ? ²
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9. Are you agreeable to a referral to a mental health professional for further help? ¹⁻⁶
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10. Would more information about your symptoms, cancer or your treatment help to ease your worries? If yes, provide relevant information or suggest resources. ¹⁻⁶

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify: _____
<input type="checkbox"/>	Referral (service & date): _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 1) ONS 2019; 2) NCCN 2018; 3) Howell 2015; 4) CCO 2019; 5) Butow 2015; 6) Li 2016; 7) Puzanov 2017; 8) Hryniewicki 2018; 9) Watanabe 2011; 10) NIH-NCI CTCAE 2017 (see pages 40-48 for full references)




Diarrhea Practice Guide

Diarrhea: An abnormal increase in stool liquidity and frequency over baseline which may be accompanied by abdominal cramping.¹⁻⁵

1. Assess severity of the diarrhea (Supporting evidence: 15 guidelines)¹⁻¹⁵

Have you been tested for c-difficile?^{1,2,4,7-12,14,15} Yes No Unsure Results _____

Tell me what number from 0 to 10 best describes your diarrhea (0="no diarrhea"; 10="worst possible diarrhea") ¹⁶	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your diarrhea? ^{2,3}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How many extra bowel movements are you having per day above normal for you? ^{1-3,5,11,14,17}	< 4 ^{G1}	<input type="checkbox"/>	4-6 ^{G2}	<input type="checkbox"/>	≥ 7 ^{≥G3}	<input type="checkbox"/>
Ostomy: increase in output above normal? ^{2,3,5,11,17}	Small	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Large	<input type="checkbox"/>
→ Bowel movements/day above normal? ^{6-10,12,15,17}			< 4 ^{G1}	<input type="checkbox"/>	≥ 4 ^{≥G2}	<input type="checkbox"/>
→ Ostomy: increase in output above normal? ⁸			Small	<input type="checkbox"/>	≥ Moderate	<input type="checkbox"/>
→ Diarrhea overnight or new incontinence? ^{6-8,10,15}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How would you describe your stools (colour, hardness, odour, amount, oily, blood, mucus, straining)? ^{1-3,5,11}					Blood in stool	<input type="checkbox"/>
→ Blood or mucus in stool? ^{6-10,12,15}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever > 38° C? ^{1-3,7-12,14,15} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have pain in your abdomen or rectum with or without cramping or bloating? ^{1-3,11}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Pain in abdomen, cramping, bloating? ^{6-10,12,13,15}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How much fluid are you drinking per day? ²	6-8 glasses	<input type="checkbox"/>	1-5 glasses	<input type="checkbox"/>	Sips	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{1-3,6-8,10,11,14}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Does your diarrhea affect your daily activities? ^{3,5,6,8,9,11,15}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have any other symptoms? ^{1-3,11} <input type="checkbox"/> Appetite Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Mouth sores	No	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ New severe fatigue, headache, rash, cough, nausea, breathlessness, weight loss, vision changes, eye pain, muscle weakness, joint pains, or mood changes? ⁸⁻¹⁰	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you on medicines that increase risk of diarrhea (e.g. laxatives)? ^{2,3,11,14}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Any recent travel or contact with others with diarrhea? ^{2,4,11}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have any rectal or ostomy skin breakdown? ^{2,3,11}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		

	 Mild (Green)	 Moderate (Yellow)	 Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 13 guidelines)^{1-3,5-12,14,15}	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately. <input type="checkbox"/> Alert clinician if on immunotherapy.

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for diarrhea, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 14 guidelines)^{1-13,18}

Current use	Examples of medications for diarrhea*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	First line treatment: Loperamide (Imodium [®]) ^{1-5,11,14,18}		Likely effective
<input type="checkbox"/>	Octreotide (Sandostatin [®]) for chemo-induced ^{1-5,11,18}		Likely effective
<input type="checkbox"/>	Psyllium fibre for radiation-induced (Metamucil [®]) ^{1,4}		Likely effective
<input type="checkbox"/>	Atropine-diphenoxylate (Lomotil [®]) ²⁻⁴		Expert opinion
<input type="checkbox"/>	Corticosteroid cream if rectal skin irritated ³		Expert opinion
<input type="checkbox"/>	→ Loperamide (Imodium [®]) for moderate diarrhea ^{6,7,9-13,15}		Expert opinion
<input type="checkbox"/>	→ Corticosteroids/prednisone ^{6-13,15} or Budesonide ^{10,11} for severe diarrhea Infliximab, ^{6-10,12,13,15} Vedolizumab ^{8-10,12}		Expert opinion

→ Immune Checkpoint Inhibitor. *For radiation induced diarrhea, sucralfate^{1,18} and oral antibiotics are generally not recommended.²

4. Review 3 or more self-care strategies (Supporting evidence: 11 guidelines)^{1-4,7-12,14}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing diarrhea? ³
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have diarrhea? ^{2,3} Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink fluids, 6-8 glasses per day? ^{1-4,7-11}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to replace electrolytes (e.g. potassium and salt)? ^{1-4,7,10,11,14} Suggest: bananas, potatoes, sports drinks, oral rehydration (1/2 tsp salt, 6 tsp sugar, 4C water)
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what kinds of foods to eat ? ^{1-3,7,8,14} Suggest: applesauce, oatmeal, bananas, barley, cooked carrots, rice, white toast, plain pasta, well cooked eggs, skinned poultry, mashed potatoes, fruit without skin (high in soluble fiber, low in insoluble fiber)
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what to avoid ? ^{1-4,7,8,10-12,14} Suggest: greasy/fried and spicy foods, alcohol, <2-3 servings caffeine, excess fruit juice or sweetened fruit drinks, raw vegetables, whole grain bread, nuts, popcorn, skins, seeds, legumes, very hot or cold foods/fluids, sorbitol in sugar-free candy, lactose-containing products (milk, yoghurt, cheese).
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat 5-6 small meals ? ^{1-3,11}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken to a dietician ? ^{1,14}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to keep skin around your rectum or ostomy clean to avoid skin breakdown (mild soap, sitz baths)? ^{2,3} Cleanse perianal skin with warm water (+/- mild soap) after each stool. ² Moisture barrier cream if not on radiation therapy. ^{2,3} Hydrocolloid dressings may be used as a physical barrier to protect skin. ³
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you been keeping track of the number of stools you are having and are you aware of other problems you should be watching for? ^{2,11} (fever, dizziness)
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a clinician or pharmacist about medications you may be taking that can cause or worsen your diarrhea ? ^{2,3,11,14}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried strategies to help with coping : carefully plan all outings, carry a change of clothes, know the location of restrooms, use absorbent undergarments. ³
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to notify in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 1) ONS 2017; 2) BCCA 2014; 3) CCO 2012; 4) Schmidt-Hieber 2018; 5) Peterson 2015; 6) BCCA 2017; 7) CCO 2018; 8) Brahmer 2018; 9) NCCN 2018; 10) Haanen 2015; 12) Puzanov 2017; 13) ONS 2017; 14) Califano 2015; 15) Hryniewicki 2018; 16) Watanabe 2011; 17) NIH-NCI CTCAE 2017 18) Lalla 2014 (see pages 40-48 for full references)

Fatigue/Tiredness Practice Guide

Fatigue: a subjective feeling of tiredness or exhaustion prompted by cancer or cancer treatment that is disproportionate to the level of recent exertion, is not relieved by rest and interferes with usual daily activities.¹⁻⁶

1. Assess severity of the fatigue/tiredness (Supporting evidence: 14 guidelines)¹⁻¹⁴

What number from 0 to 10 best describes how tired you are feeling where 0= "no tiredness" and 10= "worst possible tiredness" ^{1-5,15}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your fatigue? ^{1,3-6}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have shortness of breath at rest, sudden onset of severe fatigue, need to sit or rest too much, rapid heart rate, rapid blood loss, or pain in your chest? ^{1,2}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
How would you describe the pattern of fatigue? ^{1,2,4-6}	On an off	<input type="checkbox"/>	Constant <2 wks	<input type="checkbox"/>	Constant ≥2 wks	<input type="checkbox"/>
Does your fatigue affect your daily activities? ^{1-6,16}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Do you have a fever > 38° C? ¹⁻⁵ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you know the results of your last hemoglobin (Hgb) blood test? ¹⁻⁵ Date: <input type="checkbox"/> Unsure	<LLN-10.0g/dL	<input type="checkbox"/>	<10.0-8.0 g/dL	<input type="checkbox"/>	<8.0 g/dL	<input type="checkbox"/>
Have you lost or gained weight in the last 4 weeks without trying? ^{1,2,4,5} Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
Do you have any other symptoms? ¹⁻⁵ <input type="checkbox"/> Anxiety, <input type="checkbox"/> Pain, <input type="checkbox"/> Appetite loss, <input type="checkbox"/> Depression, <input type="checkbox"/> Sleep changes, <input type="checkbox"/> Poor fluid intake	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity). ^{3,7-13} <input type="checkbox"/> nausea, <input type="checkbox"/> appetite loss, <input type="checkbox"/> constipation, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> hair loss, <input type="checkbox"/> dry skin, <input type="checkbox"/> puffy face, <input type="checkbox"/> confusion, <input type="checkbox"/> headache	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of pneumonitis). ^{7,9,11} <input type="checkbox"/> cough, <input type="checkbox"/> wheezing, <input type="checkbox"/> breathlessness, <input type="checkbox"/> chest pain, <input type="checkbox"/> fever	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of cardiovascular toxicity). ^{7,9} <input type="checkbox"/> fast or skipped heartbeat, <input type="checkbox"/> breathlessness	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity). ^{11,14} <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea, <input type="checkbox"/> stomach pain	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of myositis). ⁷ <input type="checkbox"/> limb weakness, <input type="checkbox"/> difficulty standing up, lifting arms, moving around	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hemolytic uremic syndrome). ⁷ <input type="checkbox"/> blood in urine/stool or nose/mouth, <input type="checkbox"/> less urine, <input type="checkbox"/> new/unexplained bruises, <input type="checkbox"/> abdominal pain, <input type="checkbox"/> pale skin, <input type="checkbox"/> vomiting, <input type="checkbox"/> confusion/seizures, <input type="checkbox"/> swelling	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have conditions that cause fatigue (cardiac, lung, liver, kidney, endocrine) ¹⁻⁵ or drink excess alcohol? ^{1,2,4}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking medicines that increase fatigue? (e.g., for pain, depression, nausea/vomiting, allergies) ¹⁻⁵	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		



1 Mild
(Green)



2 Moderate
(Yellow)



3 Severe
(Red)

2. Triage patient for symptom management based on highest severity (Supporting evidence: 4 guidelines)^{1,2,4,5}

Review self-care

Review self-care.
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.

If stable, review self-care strategies
 If new, refer for non-urgent medical attention.
 Alert clinician if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for fatigue, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 4 guidelines)^{1,3-5}

Current use	Examples of medications for fatigue*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Ginseng (American or Asian) ^{3,4}		Likely effective
<input type="checkbox"/>	Methylphenidate (Ritalin [®]) ^{1,4,5}		Expert opinion
<input type="checkbox"/>	Corticosteroids: dexamethasone (Decadron [®]), prednisone ^{1,3-5}		Benefits balanced with harms

*Use of pharmacological agents for cancer-related fatigue is experimental.² Methylphenidate may be considered with caution after ruling out other causes of fatigue.^{4,5} Corticosteroids offer short-lived benefit; long-term use is associated with significant toxicities.³⁻⁵

4. Review 3 or more self-care strategies (Supporting evidence: 7 guidelines)^{1-6,17}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your fatigue? ^{1-3,5}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you feel fatigued/tired? Reinforce as appropriate. ^{1,2} Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you understand what cancer-related fatigue is ? Provide education about how it differs from normal fatigue, that it is expected with cancer treatment. ^{1-4,6}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a diary to track your fatigue patterns to help with planning activities? ^{2,4}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to save energy for things that are important to you? ¹⁻⁵
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What are you doing for physical activity including yoga? ¹⁻⁵ Set goals based on current health status. Suggest starting with light activity and gradually increase to 20 min of endurance activities (e.g. walking, jogging, swimming) and resistance activities (e.g. light weights). Use caution for patients with some conditions (e.g. bone metastases).
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you think you are eating/drinking enough to meet your body's energy needs? Staying hydrated and a balanced diet (e.g. vitamins, minerals) can help fatigue. ¹⁻⁵
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried activities like reading, games, music, garden, experiences in nature? ^{1,2,4,17}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you take part in any support groups or have family/friends you can rely on ? ¹⁻⁵
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried activities to make you more relaxed (e.g. relaxation therapy, deep breathing, guided imagery) ^{1,4} or massage with or without aromatherapy? ³
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you done any of the following to improve the quality of your sleep ? ¹⁻⁴ Ensure light exposure soon after waking; avoid long/late afternoon naps; limit time in bed to actual sleep; go to bed when sleepy; use bed for sleep and sexual activity only; have routine schedule for bedtime and getting up; avoid caffeine and stimulating activity in the evening; relax for 1 hour before going to bed; establish a bedtime routine.
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program such as cognitive behavioural therapy or mindfulness-based stress reduction to manage your fatigue? ²⁻⁵
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried home-based bright white light therapy ? ⁴
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you need a tailored plan , have you spoken or would you like to speak with a health care professional to help guide you in managing your fatigue? ¹⁻⁵ (e.g. rehabilitation specialist)
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide relevant information or suggest resources. ¹⁻⁶

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Referral (service & date): _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 2) Howell 2015; 3) ONS 2017; 4) NCCN 2018; 5) AHS 2017; 6) Bennett 2016; 7) Brahmer 2018; 8) NCCN 2018; 9) Puzanov 2017; 10) Haanen 2017; 11) CCO 2018; 12) Hryniewicki 2018; 13) BCCA 2017; 14) BCCA 2017; 15) Watanabe 2011; 16) NIH-NCI CTCAE 2017 17) Bradt 2016 (see pages 40-48 for full references).

Febrile Neutropenia Practice Guide

Febrile neutropenia: An absolute neutrophil count (ANC) < 500 cells/mcl (equivalent to < 0.5 x 10⁹/L) OR an ANC < 1000 cells/mcl (< 1.0 x 10⁹/L) and a predicted decline to 500 cells/mcl or less over the next 48 hours AND a single oral temperature of ≥38.3° C (101 °F) or a temperature of ≥38.0° C (100.4 °F) for ≥1 hour.¹⁻¹¹

1. Assess severity of the fever and neutropenia (Supporting evidence: 15 guidelines)¹⁻¹⁵


If receiving chemotherapy or immunotherapy, what was the date of your last treatment?^{2,5-7,9,10,13,15} _____

Have you been recently taking antibiotics?^{2,3,5-7,9,10} No Yes <48 hours Yes ≥48 hours

What is your temperature in the last 24 hours?¹⁻¹⁵ Current: ____ Previous temperatures: _____

Have you taken any acetaminophen (Tylenol®) or ibuprofen (Advil®),^{6,7,10} if yes, how much and when? _____

Do you have an oral temperature of ≥38.0°C (100.4 °F)? ¹⁻¹⁵	No	<input type="checkbox"/>	Yes for <1 hour	<input type="checkbox"/>	Yes for ≥1 hour	<input type="checkbox"/>
Last known neutrophil count ¹⁻¹⁶ _____ Date: <input type="checkbox"/> Unsure	>1000 cells/mcl	<input type="checkbox"/>			Fever plus ≤500 cells/mcl or 1000 cells/mcl with expected drop ^{G3}	<input type="checkbox"/>
Do you have any other symptoms? <input type="checkbox"/> Bleeding, <input type="checkbox"/> Breathlessness, <input type="checkbox"/> Constipation, <input type="checkbox"/> Diarrhea, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Mouth sores, <input type="checkbox"/> Mouth dryness, <input type="checkbox"/> Nausea, <input type="checkbox"/> Vomiting, <input type="checkbox"/> Skin reaction to radiation	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
Are you worried about your fever? ⁷	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		

 1	 2	 3
Mild (Green)	Moderate (Yellow)	Severe (Red)

<h3>2. Triage patient for symptom management based on highest severity (Supporting evidence: 15 guidelines)¹⁻¹⁵</h3>	<p><input type="checkbox"/> Review self-care</p> <p><input type="checkbox"/> Advise to notify if symptom worsens or new symptoms occur in 12-24 hours^{2,6,12}</p>	<p><input type="checkbox"/> Review self-care.</p> <p><input type="checkbox"/> Advise to notify if symptom worsens or new symptoms occur in 12-24 hours^{2,6,12}</p> <p><input type="checkbox"/> If ≥38.0° for <1 hour, advise to notify if still ≥38.0 after 1 hour.</p>	<p><input type="checkbox"/> Refer for medical attention immediately. Febrile neutropenia treatment with antibiotics should be initiated within 1 hour of presentation.^{2-7,9,12-14} Collect laboratory data to locate potential site or cause of infection prior to starting antibiotics.^{1-5,7,9,12-14}</p>
---	--	---	--

Legend: NCI-CTCAE G3=Grade 3

Note: For consistency across symptom practice guides a temperature of 38.0° C is used.

Additional Comments:

3. Review medications patient is using for preventing febrile neutropenia or decreasing fever, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 9 guidelines)^{1-3,6,10,11,13-15}

Current use	Examples of medications*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	G(M)-CSF for at-risk patients ^{1-3,6,10,11,13,15}		Effective
<input type="checkbox"/>	Antibiotics to prevent infection for high-risk patients ^{2,10,11,14,15}		Effective
<input type="checkbox"/>	Antifungals to prevent infection for at-risk patients ^{2,10,11,14}		Effective
<input type="checkbox"/>	Antivirals for select at-risk patients ^{1,2,11,14}		Effective

*Use of over the counter medications to lower fever in cancer patients (e.g., acetaminophen) is controversial and should not be used to mask a fever of unknown origin;^{7,10} G-CSF is generally recommended for patients with >20% risk of developing febrile neutropenia;^{1,3,11,15} Prophylactic antibiotic use should be limited to high risk patients with an expected duration of neutropenia for >7 days as it may promote antibiotic resistance.^{2,10,11,14,15} Antifungal prophylaxis should be reserved for a targeted group of high-risk patients with an expected duration of neutropenia for >7 days.^{2,10,11,14} Antiviral prophylaxis is recommended for select patients at risk for certain viral infections or reactivation of viral infection.^{1,2,11,14}

4. Review 3 or more self-care strategies (Supporting evidence: 13 guidelines)^{1-3,5-14}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If temperature not $\geq 38.0^{\circ}$ C, are you checking your body temperature with a thermometer by mouth? ^{3,8,10} Avoid rectal temperature measurements. ^{2,7}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you washing your hands frequently and/or using alcohol-based sanitizer? ^{1,10,11,14}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink fluids , 6-8 glasses per day to stay hydrated? ^{1,3,5-7,9-11,14}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding enemas, suppositories, tampons, and invasive procedures ? ^{1,2,5,7,10} Constipation and straining during bowel movements can cause trauma to rectal tissue. ¹⁰
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid crowds and people who might be sick ? ^{1,10}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you eating well cooked foods and/or well cleaned uncooked raw fruits and vegetables? ^{1,10,11}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you brushing your teeth with a soft toothbrush at least twice a day? ^{1,10} Floss daily if it is your normal routine and tolerated.
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking daily showers or baths? ^{1,10}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you checking your mouth and your skin for potential sites of infection (e.g. access devices, rectal area) and keeping these areas clean and dry? ^{1-3,5,7,10,13}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken to a clinician about getting an annual flu shot and other vaccines (with inactivated vaccine)? ^{1,2,10,11,14} All visitors and household members should be up-to-date with vaccines (e.g. influenza, measles, mumps, rubella, and varicella).
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources. ^{2,3,7-10,12}

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------




References: 1) Freifeld 2011; 2) NCCN 2018; 3) Klastersky 2016; 4) Tam 2011; 5) AHS 2014; 6) CCMB 2017; 7) CCNS 2014; 8) Krzyzanowska 2016; 9) Taplitz 2018; 10) BCCA 2014; 11) ONS 2017; 12) NICE 2012; 13) NICaN 2015; 14) Flowers 2013; 15) Neumann 2013; 16) NIH-NCI CTCAE 2017 (see pages 40-48 for full references).

Mouth Dryness/Xerostomia Practice Guide

Xerostomia: abnormal dryness in the oral cavity due to a reduction and/or thickening of saliva produced; the subjective experience of dry mouth secondary to salivary gland hypofunction; may be acute or chronic.¹⁻³

1. Assess severity of the dry mouth (Supporting evidence: 5 guidelines)¹⁻⁵

What number from 0 to 10 best describes your dry mouth where 0= "no dry mouth" and 10= "worst possible dry mouth"? ^{1,2,6}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your dry mouth? ¹⁻³	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Is your saliva thick or less saliva than normal? ^{1,2,7}	No/A bit ^{G1}	<input type="checkbox"/>	Somewhat ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Is your mouth painful? ^{1,2}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you see any redness, white patches, cracks, or blisters in your mouth? ¹⁻³	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a fever >38°C? ^{1,2} <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is your mouth bleeding? ²	No	<input type="checkbox"/>	Yes, with eating or oral hygiene	<input type="checkbox"/>	Yes, spontaneously	<input type="checkbox"/>
Are you able to eat? ^{1-3,7}	Yes ^{G1}	<input type="checkbox"/>	Yes, soft food ^{G2}		No ^{G≥3}	<input type="checkbox"/>
How much fluid are you drinking per day? ^{1,2,4}	6-8 glasses	<input type="checkbox"/>	1-5 glasses		Sips/Unable to swallow	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ^{1,2,4}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Do you have (signs of diabetic ketoacidosis): ⁸ <input type="checkbox"/> increased thirst, <input type="checkbox"/> frequent urination, <input type="checkbox"/> fruity breath odour <input type="checkbox"/> stomach pain, <input type="checkbox"/> weakness, <input type="checkbox"/> fast heart rate <input type="checkbox"/> vomiting, <input type="checkbox"/> confusion, <input type="checkbox"/> dry skin?	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of uveitis): <input type="checkbox"/> dry eyes, <input type="checkbox"/> eye pain, <input type="checkbox"/> eye redness, <input type="checkbox"/> blurred/double vision? ^{9,10}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your dry mouth affect your ability to speak? ¹⁻³	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you having taste changes? ¹⁻³	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Have you lost weight in the last 1-2 weeks without trying? ^{1,2} Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
Do you have trouble breathing? ^{1,2} If yes, see breathlessness guide	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Are you taking any medications that can cause dry mouth? ^{1-3,5} (e.g. anticholinergics, antiemetics)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does your dry mouth affect your daily activities? ^{1,2}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Are you feeling worried? ^{1,2} If yes, see Anxiety guide.	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, often	<input type="checkbox"/>

	 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 1 guidelines)¹	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately <input type="checkbox"/> Alert clinician if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for dry mouth, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 5 guidelines)¹⁻⁵

Current use	Examples of medications for dry mouth	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Pilocarpine (Salagen [®]) saliva stimulant ³		Expert opinion
<input type="checkbox"/>	Anetholtrithion (Sialor [®]) salivary stimulant ^{1,5}		Expert opinion
<input type="checkbox"/>	Saliva substitutes (Biotene [®] , Moi-Stir [®]) ¹⁻⁵		Expert opinion
<input type="checkbox"/>	Oral medications for pain ^{1,2}		Expert opinion

4. Review 3 or more self-care strategies (Supporting evidence: 5 guidelines)¹⁻⁵

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your dry mouth? ^{1,2}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have a dry mouth? ^{1,2} Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 6-8 glasses of clear fluids per day? ¹⁻⁵
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding foods and drinks that are highly acidic, caffeinated, sugary, salty, spicy, or very hot (temperature)? ^{1-3,5}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have difficulty swallowing, are you trying to eat a soft diet ? ^{1,2} Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes. Add extra moisture to foods using sauce, dressing, gravy, broth, or butter/margarine.
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you keeping your mouth cool and moist with fresh, cold foods? Suggest sugar-free popsicles, frozen grapes, cold water, ice cubes, or lightly acidic fruit (e.g. cucumber, apples, tomato). ^{1,2,4}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to brush your teeth at least twice a day using a soft toothbrush and fluoride toothpaste? ¹⁻⁵ Floss daily if it is your normal routine and tolerated.
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you wear dentures, are you removing before brushing your teeth, cleaning them with toothpaste, and leaving them off for long periods of time (e.g. overnight)? ^{1,2,4,5}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use a bland rinse 4 times/day ? ¹⁻⁵ For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. Prepare daily.
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you chewing on sugar-free gum or sucking on hard candy to help create saliva? ¹⁻⁵ Xylitol gum or lozenges can also be used, up to 6 grams a day. ²
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid tobacco and alcohol , including alcohol-based mouthwashes? ^{1,2,4,5}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using moisturizers to protect your lips? ^{1,2,4,5}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using saliva substitutes (gel, mouthwash, spray)? ¹⁻⁵ If so, how long have you been using them, and do they help? Discourage use of glycerin-based swab sticks.
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using a cool humidifier or bedside vaporizer to help reduce the dryness? ¹
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you considered trying acupuncture therapy to help stimulate saliva production? ¹⁻³
16. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide relevant information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____	
<input type="checkbox"/>	Referral (service & date): _____	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____	
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date




References: 1) BCCA 2014; 2) CCO 2012; 3) AAOM 2016; 4) NICaN 2015; 5) Peterson 2015; 6) Watanabe 2011; 7) NIH-NCI 2017; 8) NCCN 2018; 9) Puzanov 2017; 10) Brahmer 2018 (see pages 40-48 for full references)

Mouth Sores/Stomatitis Practice Guide

Mouth sores/Stomatitis/Oral Mucositis: An inflammatory and potentially ulcerative process of the mucous membranes, that can result in severe discomfort that can impair patients' ability to eat, swallow, and talk, and is accompanied by a risk for life-threatening bacteremia and sepsis.¹⁻⁵

1. Assess severity of the mouth sores (Supporting evidence: 6 guidelines)¹⁻⁶

What number from 0 to 10 best describes your mouth sores where 0= "no mouth sores" and 10= "worst possible mouth sores"? ^{2,3,7}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your mouth sores? ^{2,3}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
How many sores/ulcers/blisters do you have? ¹⁻⁶	0-4	<input type="checkbox"/>	>4	<input type="checkbox"/>	Coalescing/ Merging/Joining	<input type="checkbox"/>
Do the sores in your mouth bleed? ^{1-3,6}	No	<input type="checkbox"/>	Yes, with eating or oral hygiene	<input type="checkbox"/>	Yes, spontaneously	<input type="checkbox"/>
Are the sores painful? ^{1-5,8}	No/Mild ^{G1} 0-3	<input type="checkbox"/>	Moderate ^{G2} 4-6	<input type="checkbox"/>	Severe ^{G≥3} 7-10	<input type="checkbox"/>
Do you see any redness or white patchy areas in your mouth? ¹⁻⁶	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have a fever > 38° C? ¹⁻³ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have a dry mouth? ^{2,3,5}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you able to eat? ¹⁻⁵ If no, can you open and close your mouth? ²	Yes	<input type="checkbox"/>	Yes, soft food	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine, dark urine? ^{1-3,5}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
How much fluid are you drinking per day? ^{1-3,5}	6-8 glasses	<input type="checkbox"/>	1-5 glasses		Sips/Unable to swallow	<input type="checkbox"/>
Have you lost weight in the last 1-2 weeks without trying? ¹⁻³ Amount: <input type="checkbox"/> Unsure	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
Are you having trouble breathing? ^{2,3}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Does your mouth sore(s) affect your daily activities? ^{2,3}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>

	 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 6 guidelines)¹⁻⁶	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately.

Legend: NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for mouth sores, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 7 guidelines)^{1-6,9}

Current use	Examples of medications for mouth sores	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzydamine hydrogen chloride (Tantum [®] mouth rinse) ^{1,3,5,6}		Likely effective
<input type="checkbox"/>	Oral medications ²⁻⁵ , morphine mouth wash, ⁹ topical anesthetics (lidocaine), ²⁻⁴ transdermal fentanyl ^{4,9} for pain		Expert opinion
<input type="checkbox"/>	0.5% Doxepin mouth rinse for pain ^{4,9}		Expert opinion
<input type="checkbox"/>	Mucosal coating agents for pain (Gelclair [®]) ²⁻⁶		Expert opinion
<input type="checkbox"/>	Saliva substitutes (Biotene [®] , Moi-Stir [®] , Caphosol [®]) ²⁻⁶		Expert opinion
<input type="checkbox"/>	Topical steroids for mouth sores from targeted therapies ^{4,5}		Expert opinion
<input type="checkbox"/>	Nystatin for oral candida ^{2,5,6}		Expert opinion

* Some benzydamine HCl formulations contain alcohol and can cause stinging.⁵ Chlorhexidine mouth rinse and sucralfate are not recommended for treatment.^{1-6,9} "Magic" Mouthwash (mixed medication mouthwash) is not recommended for practice.¹ Local anesthetics for short term pain relief can make it hard to swallow; if used patients should be advised about increased risk of choking when eating.^{1,3}

4. Review 3 or more self-care strategies (Supporting evidence: 7 guidelines)^{1-6,9}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your mouth sores? ^{2,3}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have mouth sores? ^{2,3} Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use a bland rinse 4 times/day (more often if mouth sores)? ^{1-6,9} For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. ^{1,2,4} Prepare daily.
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to brush your teeth at least twice a day using a soft toothbrush (use soft foam toothette in salt/soda water if sores)? ^{1-6,9} Floss daily if it is your normal routine and tolerated.
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you rinse your toothbrush in hot water before using and allow to air dry? ¹⁻³
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you wear dentures and mouth sensitive, do you use dentures only at mealtimes ? ^{1-4,6}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using moisturizers to protect your lips? ¹⁻⁶
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you sucking on lactobacillus lozenges ¹ or zinc lozenges ^{2,4} to prevent mouth sores?
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to avoid tobacco and alcohol , including alcohol-based mouthwashes? ¹⁻⁶
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 6-8 glasses of fluids per day? ¹⁻⁶
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to eat a soft diet ? ^{1-4,6} Suggest: oatmeal, bananas, applesauce, cooked carrots, rice, pasta, eggs, mashed potatoes, cooked or canned fruit without skin, soft cheese, creamed soups, puddings/milkshakes
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If on pain medicine , have you tried taking it before meals for relief while eating? ¹⁻⁴
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding foods/drinks that are acidic, salty, spicy , or very hot? ^{1-4,6}
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If eating is difficult, have you spoken with a dietitian or tried meal supplements? ^{1-3,5,6}
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	During chemotherapy, are you taking ice water, ice chips , ice lollipops for 30 min? ^{1-4,6,9}
16. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? ^{2,4,6} If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____
<input type="checkbox"/>	Referral (service & date): _____
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 1) ONS 2017; 2) CCO 2012; 3) BCCA 2014; 4) Peterson 2015; 5) NICaN 2015; 6) Califano 2015; 7) Watanabe 2011; 8) NIH-NCI CTCAE 2017; 9) Lalla 2014 (see pages 40-48 for full references)

Nausea & Vomiting Practice Guide

Nausea: A subjective perception that emesis may occur. Feeling of queasiness.¹ Vomiting: A forceful expulsion of stomach contents through the mouth and may include retching/dry heaves (gastric and esophageal movement without vomiting).¹

1. Assess severity of nausea/vomiting (Supporting evidence: 10 guidelines)¹⁻¹⁰

What number from 0 to 10 best describes how you are feeling 0="No nausea" and 10="Worst possible nausea" ^{1,2,11}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your nausea/vomiting? ^{1-3,5}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
If vomiting: How many times per day? ^{1-3,5,12}	≤1 ^{G1}	<input type="checkbox"/>	2-5 ^{G2}	<input type="checkbox"/>	≥6 ^{G≥3}	<input type="checkbox"/>
What is the amount of vomit? ¹⁻³	Small	<input type="checkbox"/>	Modest	<input type="checkbox"/>	Large	<input type="checkbox"/>
Is there any blood or look like coffee grounds? ¹⁻³	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you been able to eat within last 24 hours? ¹⁻³	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>		
Have you lost weight in the last 1-2 weeks without trying? ¹⁻³	0-2.9%	<input type="checkbox"/>	3-9.9%	<input type="checkbox"/>	≥10%	<input type="checkbox"/>
How much fluid are you drinking per day? ¹⁻⁴	6-8 glasses	<input type="checkbox"/>	1 to 5 glasses	<input type="checkbox"/>	Sips	<input type="checkbox"/>
Are you feeling dehydrated, which can include feeling dizzy, a dry mouth, increased thirst, feeling faint, rapid heart rate, decreased amount of urine? ¹⁻⁴	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have any abdominal pain? ¹⁻³	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Does your nausea/vomiting affect your daily activities? ^{1,2,4}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Are you taking medicines that can cause nausea/vomiting? ¹⁻⁵ (e.g. opioids, antidepressants, antibiotics, warfarin)	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have any other symptoms? ¹⁻⁵ <input type="checkbox"/> Pain <input type="checkbox"/> Fever <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Anxiety <input type="checkbox"/> Headache	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ⁶⁻⁹ <input type="checkbox"/> fatigue, <input type="checkbox"/> appetite loss, <input type="checkbox"/> constipation, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> hair loss, <input type="checkbox"/> dry skin, <input type="checkbox"/> puffy face, <input type="checkbox"/> confusion, <input type="checkbox"/> headache	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of autonomic neuropathy): ^{6,7,10} <input type="checkbox"/> constipation, <input type="checkbox"/> urinary problems, <input type="checkbox"/> sweating changes	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of aseptic meningitis): ^{6,7,10} <input type="checkbox"/> headache, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> neck stiffness	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ^{6,8} <input type="checkbox"/> dark urine, <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> fever, <input type="checkbox"/> fatigue, <input type="checkbox"/> abd pain	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of GI toxicity): ^{6,10} <input type="checkbox"/> abd pain, <input type="checkbox"/> blood or mucus in stool, <input type="checkbox"/> fever, <input type="checkbox"/> weight loss	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hemolytic uremic syndrome): ⁶ <input type="checkbox"/> blood in urine/stool or nose/mouth, <input type="checkbox"/> less urine, <input type="checkbox"/> new/unexplained bruises, <input type="checkbox"/> abd pain, <input type="checkbox"/> pale skin, <input type="checkbox"/> fatigue, <input type="checkbox"/> confusion/seizures, <input type="checkbox"/> swelling	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity (Supporting evidence: 3 guidelines)¹⁻³

<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.	<input type="checkbox"/> Refer for medical attention immediately. <input type="checkbox"/> Alert clinician if on immunotherapy
---	---	---

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for nausea/vomiting, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 8 guidelines)^{1-5,13-15}

Current use	Examples of medications for nausea/vomiting*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	5-HT ₃ : ondansetron (Zofran [®]), granisetron (Kytril [®]), dolasetron (Anszemet [®]) ^{1-5,13,14}		Effective
<input type="checkbox"/>	Olanzapine (Zyprexa [®]) ^{2,4,5,13,14}		Effective
<input type="checkbox"/>	Fosaprepitant (Emend [®] IV), aprepitant (Emend [®]) ^{1,4,5,13,14}		Effective
<input type="checkbox"/>	Triple drug: dexamethasone, 5 HT ₃ (palonosetron), neurokinin 1 receptor antagonist (netupitant) for high emetic risk ^{4,5,13,14}		Effective
<input type="checkbox"/>	Cannabis/Cannabinoids ^{2,4,13,15}		Effective
<input type="checkbox"/>	Netupitant/palonosetron (NEPA) (Akinzeo [®]) ^{4,5,13,14}		Effective
<input type="checkbox"/>	Dexamethasone (Decadron [®]) alone or in combination ^{1-5,13,14}		Likely effective
<input type="checkbox"/>	Gabapentin (Neurontin [®]) ¹³		Likely effective
<input type="checkbox"/>	Progestins ¹³		Likely effective
<input type="checkbox"/>	Lorazepam (Ativan [®]) ^{1-5,13,14} , haloperidol (Haldol [®]) ¹⁻⁴		Expert opinion
<input type="checkbox"/>	Metoclopramide (Maxeran [®]) ^{1-5,14} , prochlorperazine (Stemetil [®]) ^{1,14}		Expert opinion
<input type="checkbox"/>	Other: Cyclizine, ^{3,5} dimenhydrinate ^{1,2} , methotrimeprazine ¹		Expert opinion

*Patients are at increased risk of opioid overdose and serious side effects when taking gabapentin with an opioid.¹⁶ Rectal administration should be avoided if neutropenic.

4. Review 3 or more self-care strategies (Supporting evidence: 6 guidelines)^{1-5,13}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your nausea and vomiting? ^{4,13}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have nausea/vomiting? ^{1,2} Reinforce as appropriate. Specify:
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to drink 6-8 glasses clear fluids per day? ^{1,2,4}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried relaxation techniques (e.g. guided imagery, music therapy, progressive muscle relaxation, and/or hypnosis)? ^{1,2,4,5,13}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you taking fast-acting anti-emetics before meals so they are effective during/after meals? ^{1,2}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If vomiting, are you limiting food and drink until vomiting stops ? After 30-60 min without vomiting, sip clear fluids. When clear fluids stay down, add dry starchy foods (crackers, dry toast, dry cereal, pretzels). If starchy foods stay down, add protein rich foods (e.g. eggs, chicken). ^{1,2}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If nausea are you trying to: Eat 5-6 small meals ? ¹⁻⁴ Eat foods that reduce your nausea and are your "comfort foods" cold or room temperature? ^{1,2,4} Avoid greasy/fried, highly salty, spicy, and foods with strong odors? Avoid tobacco and alcohol? ^{1,4,5}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you sitting upright or reclining with head raised for 30-60 minutes after meals? ^{1,2}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If vomiting, are you trying to use a bland rinse 4 times/day ? ² For 1 cup warm water, add table salt (2.5 ml (1/2 tsp.)), baking soda (1/2 tsp.) or both (1/4 tsp. each). Swish in your mouth for at least 30 seconds and spit out. Prepare daily.
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried acupuncture or acupressure to help with your nausea/vomiting? ^{1,2,4}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you spoken with a dietitian? ^{1,2,4}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? ¹⁻³ If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use	
<input type="checkbox"/>	Patient agrees to try self-care items #: _____ How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)? _____	
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify: _____	
<input type="checkbox"/>	Referral (service & date): _____	
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame: _____	
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur	
Name	Signature	Date

References: 1) BCCA 2014; 2) CCO 2019; 3) NCCN 2015; 4) NCCN 2019; 5) Roila 2019; 6) Brahmer 2018; 7) NCCN 2018; 8) CCO 2018; 9) Puzanov 2017; 10) Haanen 2017; 11) Watanabe 2011; 12) NIH-NCI CTCAE 2017; 13) ONS 2017; 14) Hesketh 2017; 15) Smith 2015; 16) Health Canada 2019 (see pages 40-48 for full references)

Pain Practice Guide

Pain: subjective sensory or emotional discomfort associated with actual or potential tissue damage or described in terms of such damage.¹⁻⁵ Types of pain are classified as nociceptive or neuropathic. Nociceptive pain arises from stimulation of pain receptors within the tissue, which has been damaged or involved in an inflammatory process,^{1,2,5,6} divided into a) somatic pain in skin, muscle and bone described as aching, stabbing, throbbing, and/or pressure and; b) visceral pain in organs or viscera described as gnawing, cramping, aching, or sharp.^{1,2} Neuropathic pain from nerve damage is described as burning, tingling, shooting, or pins/needles.^{1,2,5,6}

1. Assess the pain and severity (Supporting evidence: 15 guidelines)¹⁻¹⁵

Tell me about the pain (location, onset, radiating, what does it feel like, what makes it better or worse):¹⁻⁹ _____

Do you know what may be causing the pain (surgery, injury, illness, pre-existing pain/arthritis, spinal cord compression)?^{1,2,4-6,9}

What number from 0 to 10 best describes your level of pain where 0="No pain" and 10="Worst possible pain" ^{1,2,5-8,16}	0 – 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Rating of worst pain and pain 2hr after medicine? ^{1,2,6,7}	0 - 3	<input type="checkbox"/>	4 – 6	<input type="checkbox"/>	7 - 10	<input type="checkbox"/>
Are you able to easily distract yourself from the pain? ⁶	Yes, often	<input type="checkbox"/>	Yes, sometimes	<input type="checkbox"/>	No, never	<input type="checkbox"/>
Are you worried about your pain? ^{1,2,5,6,8,9}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Was the pain onset sudden? ^{1-3,5-8}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Is the pain from a new location? ^{1,2,5,6,8} Describe.	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Yes	<input type="checkbox"/>
Do you have loss of bladder or bowel control, numbness in your fingers, toes or buttocks, feel unsteady on your feet, or difficulty walking? ¹	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you feel confused, very sleepy, hallucinate, or have muscle spasms? ^{1,2,6}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your pain interfere with your daily activities? ^{1,2,5-8,17}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
Does your pain interfere with your mood? ^{1,2,5,6}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		<input type="checkbox"/>
Are you able to get pain relief from your medicines? ^{1,2,5,6}	Yes, relief	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	No	<input type="checkbox"/>
Do the pain medicines restrict your daily activities? ^{1,2,5,6}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have (risk factors for opioid misuse): ^{2,5,6} <input type="checkbox"/> past alcohol or drug misuse, <input type="checkbox"/> psychiatric disorder, <input type="checkbox"/> younger age, <input type="checkbox"/> legal problems, <input type="checkbox"/> past sexual abuse, <input type="checkbox"/> poor financial and/or social support <input type="checkbox"/> current heavy smoker?	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have other symptoms: ^{1,2,4-6,9} <input type="checkbox"/> Constipation, <input type="checkbox"/> Nausea/ Vomiting, <input type="checkbox"/> Depression, <input type="checkbox"/> Fatigue, <input type="checkbox"/> Sleep changes, <input type="checkbox"/> Itchiness, <input type="checkbox"/> Peripheral neuropathy	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
→ Do you have (signs of musculoskeletal toxicities): ¹⁰⁻¹⁴ <input type="checkbox"/> joint pain/swelling, <input type="checkbox"/> stiffness after inactivity, <input type="checkbox"/> muscle weakness, <input type="checkbox"/> movement/heat improves pain	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of hepatic toxicity): ^{10,11,13} <input type="checkbox"/> right side abdominal pain <input type="checkbox"/> fatigue, <input type="checkbox"/> yellow skin/eyes, <input type="checkbox"/> dark urine, <input type="checkbox"/> fever, <input type="checkbox"/> nausea	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of endocrine toxicity): ^{10,11,13,14} <input type="checkbox"/> abdominal pain, <input type="checkbox"/> nausea, <input type="checkbox"/> fatigue, <input type="checkbox"/> appetite loss, <input type="checkbox"/> constipation, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> hair loss, <input type="checkbox"/> dry skin, <input type="checkbox"/> puffy face, <input type="checkbox"/> confusion	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
→ Do you have (signs of ocular toxicity): ¹⁰⁻¹² <input type="checkbox"/> pain with eye movement, <input type="checkbox"/> vision changes, <input type="checkbox"/> eyes sensitive to light, <input type="checkbox"/> eyelid swelling	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>



Mild
(Green)



Moderate
(Yellow)



Severe
(Red)

2. Triage patient for symptom management based on highest severity (Supporting evidence: 4 guidelines)^{1,2,5,6}

Review self-care
 Review medications

Review self-care.
 Review medications
 Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.

Refer for medical attention immediately
 Alert clinician if on immunotherapy

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for pain, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 14 guidelines)¹⁻¹⁴

Current use	Examples of medications for pain*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	1 Non-opioid: ^{1-3,6,8-14} acetaminophen (Tylenol [®]), NSAIDs, COX-2 inhibitors, nefopam (Acupan [®])		Likely effective
<input type="checkbox"/>	2 Weak opioid: ^{2,3,6,8,9} codeine, tramadol, tapentadol		Effective
<input type="checkbox"/>	3 Strong opioid: ^{1,2,6,8,9} morphine, oxycodone, fentanyl, hydromorphone		Effective
<input type="checkbox"/>	Breakthrough pain: ^{1,2,5-8} extra dose of immediate-release oral opioids or transmucosal fentanyl		Effective
<input type="checkbox"/>	Chronic pain: ^{2,9} Transdermal buprenorphine, transdermal fentanyl, systemic anesthetics (e.g. mexiletine)		Effective
<input type="checkbox"/>	Chronic pain: ^{2,9} Cannabis/Cannabinoids		Likely effective
<input type="checkbox"/>	Refractory pain: ^{4,8} Ketamine		Benefits balanced with harm
<input type="checkbox"/>	Neuropathic pain: ^{1-3,6,8,9} Antidepressant or anticonvulsant		Likely effective
<input type="checkbox"/>	→ Prednisone for immunotherapy-related pain ¹⁰⁻¹⁵		Expert opinion
<input type="checkbox"/>	Constipation prophylaxis: ^{1,2,6,8} stimulant (sennosides or bisocodyl) plus osmotic laxative (lactulose or PEG)		Likely effective/ expert opinion

*Use NSAIDs with caution due to risk of renal, GI, or cardiac toxicities, thrombocytopenia, or bleeding disorder.^{2,6} Avoid use of long-acting opioids during severe acute pain.^{1,2,6,8} Use opioids with caution in patients with kidney or liver dysfunction.^{1,2,6,8} Avoid tricyclic antidepressants in the elderly.⁶

4. Review 3 or more self-care strategies (Supporting evidence: 9 guidelines)^{1-3,5-9,18}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for pain relief (e.g., target on scale of 0 to 10)? ^{1,2,6,7}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have family or a friend helping you manage your pain? ^{1,2,6}
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you understand the plan for taking routine and breakthrough medicines for pain? If no, educate about pain and pain management. ^{1,2,5,6,8,9}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any concerns about taking pain medicines ? If yes, explore and educate. ^{1-3,5}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you tracking your pain level when taking medicine and 1-2 hr. after? ^{1,5}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have pain? Reinforce as appropriate. ^{1,2,6,8}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried massage (+/- aromatherapy), physio , acupuncture , heat/cold, or transcutaneous electrical nerve stimulation? ^{1,2,6}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you doing any light physical activity (walk, swim, cycle, stretch)? ^{1,2,6}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using activities to help you cope with pain (e.g. listening to music, breathing exercises, activities for distraction, relaxation, mindfulness-based stress reduction, guided imagery, hypnosis)? ^{1-3,6,18}
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If taking opioids, are you using medicines to prevent constipation ? ^{1,2,6,8}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have other symptoms, are they under control? ²

5. Summarize and document plan agreed upon with patient (check all that apply)

- No change, continue with self-care strategies and if appropriate, medication use
- Patient agrees to use medication to be consistent with prescribed regimen
- Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not, 10=very)?
- Referral (service & date):
- Patient agrees to seek medical attention; specify time frame:
- Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 1) BCCA 2014; 2) NCCN 2019; 3) ONS Acute Pain 2019; 4) ONS Refractory/Intractable Pain 2019; 5) Daeninck 2016; 6) CCO 2018; 7) ONS Breakthrough Pain 2019; 8) Yamaguchi 2013; 9) ONS Chronic Pain 2019; 10) Brahmer 2018; 11) NCCN 2018; 12) Puzanov 2017; 13) CCO 2018; 14) Haanen 2017; 15) Hryniewicki 2018; 16) Watanabe 2011; 17) NIH-NCI CTCAE 2017; 18) Bradt 2016 (see pages 40-48 for full references)

Peripheral Neuropathy Practice Guide

Neuropathy: Numbness, tingling, burning, pins and needles, tremor, balance disturbances, pain in hands, feet, legs or arms. The end result of peripheral, motor, sensory, and autonomic neuron damage caused by neurotoxic chemotherapy agents that inactivate the components required to maintain the metabolic needs of the axon.¹⁻⁴ Other causes of peripheral neuropathy include surgical trauma, treatment with immune checkpoint inhibitors, and radiation involving the spine.^{1,3}

1. Assess severity of the neuropathy (Supporting evidence: 10 guidelines)¹⁻¹⁰

If receiving chemotherapy, what was the date of your last treatment? _____

Tell me about the neuropathy (location, onset, radiating, what does it feel like, what makes it better or worse):^{1,3}

What number from 0 to 10 best describes your neuropathy where 0="No neuropathy" and 10="Worst possible neuropathy" ^{1,3,11}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your neuropathy? ^{6,9}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have pain in your _____ (neuropathy location)? ¹⁻⁴	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
→ Pain in lower back or thighs ^{6,9}	No 0	<input type="checkbox"/>	Mild 1-3	<input type="checkbox"/>	> Moderate 4-10	<input type="checkbox"/>
Do you have new weakness in your arms or legs? ^{1,2}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Rapid onset of weakness in arms or legs ^{5-7,9}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you noticed problems with your balance or how you walk or climb stairs? ^{1,2,5} If yes, how much?	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Are you constipated? ¹	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
Do you have difficulty emptying your bladder of urine? ¹	No/Mild	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
→ Constipation or urinary problems ⁶	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Does your neuropathy/numbness/tingling affect your daily activities? (e.g. buttoning clothing, writing, holding coffee cup)? ^{1,12}	No ^{G1}	<input type="checkbox"/>	Yes, some ^{G2}	<input type="checkbox"/>	Yes, a lot ^{G≥3}	<input type="checkbox"/>
→ Neuropathy interferes with daily activities ^{5-10,12}	No ^{G1}	<input type="checkbox"/>			Yes ^{G≥2}	<input type="checkbox"/>
→ Do you have: <input type="checkbox"/> Difficulty walking, <input type="checkbox"/> Vision changes, <input type="checkbox"/> Breathlessness, <input type="checkbox"/> Swallowing or speaking problems, <input type="checkbox"/> Nausea, <input type="checkbox"/> Sweating changes? ⁵⁻¹⁰	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>

 1 Mild (Green)	 2 Moderate (Yellow)	 3 Severe (Red)
---	--	---

2. Triage patient for symptom management based on highest severity

(Supporting evidence: 8 guidelines)^{1,3,5-10}

<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications	<input type="checkbox"/> Review self-care <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 1-2 days.	<input type="checkbox"/> Refer for medical attention immediately <input type="checkbox"/> Alert clinician if on immunotherapy
--	--	--

Legend: → Immune Checkpoint Inhibitor therapy; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for neuropathy, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 11 guidelines)^{1-10,13}

Current use	Examples of medications for neuropathy*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Duloxetine ^{2-4,6,8,9,13}		Likely effective
<input type="checkbox"/>	Gabapentin (Neurontin [®]) and opioid combination ^{2,3}		Likely effective
<input type="checkbox"/>	Corticosteroids - prednisone/methylprednisolone ^{1,3,5-10}		Expert opinion
<input type="checkbox"/>	Anti-convulsants gabapentin, pregabalin (Lyrica [®]) ^{1,3,4,6,8,9,13}		Expert opinion
<input type="checkbox"/>	Tricyclic anti-depressants: amitriptyline (Elavil [®]), nortriptyline (Pamelor [®]), duloxetine (Cymbalta [®]), venlafaxine (Effexor [®]), bupropion (Wellbutrin [®] , Zyban [®]) ^{1,3,4,13}		Expert opinion
<input type="checkbox"/>	Opioids – fentanyl, morphine (Statex [®]), hydromorphone (Dilaudid [®]), codeine, oxycodone (OxyContin [®]), tapentadol (Nucynta [®]), methadone (Dolophine [®]) ^{1,3}		Expert Opinion
<input type="checkbox"/>	Topical – lidocaine patch 5% ^{1,3}		Expert Opinion

*Opioids combined with anticonvulsants or anti-depressants increase CNS adverse events requiring careful titration. Avoid tricyclic antidepressants in the elderly.⁴ Carnitine/L-carnitine and human leukemia inhibitory factor are not recommended for practice.^{2,13}

4. Review 3 or more self-care strategies (Supporting evidence: 3 guidelines)¹⁻³

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
			1. What is your goal in managing the neuropathy? ^{1,3}
	<input type="checkbox"/>	<input type="checkbox"/>	2. <input type="checkbox"/> What helps with managing your neuropathy? ¹ Reinforce as appropriate.
	<input type="checkbox"/>	<input type="checkbox"/>	3. <input type="checkbox"/> Do you look at your hands and feet every day for sores/blisters that you may not feel? ¹
	<input type="checkbox"/>	<input type="checkbox"/>	4. <input type="checkbox"/> Neuropathy in feet: Do you have footwear that fits you properly? ^{1,2}
	<input type="checkbox"/>	<input type="checkbox"/>	5. <input type="checkbox"/> Neuropathy in hands: Do you wear gloves when cooking, using oven, or doing dishes? ^{1,2}
	<input type="checkbox"/>	<input type="checkbox"/>	6. <input type="checkbox"/> In your home: Are the walkways clear of clutter? ¹ Do you have a skid-free shower or using bath mats in your tub? ^{1,2} Have you removed throw rugs that may be a tripping hazard? ^{1,2}
	<input type="checkbox"/>	<input type="checkbox"/>	7. <input type="checkbox"/> When walking on uneven ground , do you try to look at the ground to help make up for the loss of sensation in your legs or feet? ¹
	<input type="checkbox"/>	<input type="checkbox"/>	8. <input type="checkbox"/> If any neuropathy, to avoid burns: Have you lowered the temperature of your hot water heater? ^{1,2} Do you use a thermometer to ensure shower or tub water is <120°F/49°C? ^{1,2}
	<input type="checkbox"/>	<input type="checkbox"/>	9. <input type="checkbox"/> Are you avoiding exposing your fingers and toes to very cold temperatures ? ¹
	<input type="checkbox"/>	<input type="checkbox"/>	10. <input type="checkbox"/> Do you try to dangle your legs before you stand up to avoid feeling dizzy? ¹
	<input type="checkbox"/>	<input type="checkbox"/>	11. <input type="checkbox"/> For constipation , do you try eat a high-fiber diet and drink adequate fluids ? ^{1,3}
	<input type="checkbox"/>	<input type="checkbox"/>	12. <input type="checkbox"/> For urinary issues do you try to empty bladder at same time every day, bladder re-training exercises, and drink adequate fluids? ¹
	<input type="checkbox"/>	<input type="checkbox"/>	13. <input type="checkbox"/> Have you tried acupuncture , massage, yoga, relaxation therapy, or guided imagery? ^{1,3}
	<input type="checkbox"/>	<input type="checkbox"/>	14. <input type="checkbox"/> Have you spoken with a physiotherapist about: A walker, cane, or splint to help with balance and improve walking, physical training plan or transcutaneous electrical nerve stimulation? ¹⁻³
	<input type="checkbox"/>	<input type="checkbox"/>	15. <input type="checkbox"/> Have you spoken with an occupational therapist about using loafer-style shoes or Velcro shoe laces, adaptive equipment (e.g. larger handles on eating utensils)? ¹
	<input type="checkbox"/>	<input type="checkbox"/>	16. <input type="checkbox"/> Have you spoken with a clinician or pharmacist or dietitian about the peripheral neuropathy? ^{1,3}
	<input type="checkbox"/>	<input type="checkbox"/>	17. <input type="checkbox"/> Would more information about your symptoms help you to manage them better? ¹ If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 1-2 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 1) BCCA 2014; 2) ONS 2019; 3) NCCN 2019; 4) CCO 2018; 5) BCCA 2017; 6) Brahmer 2018; 7) CCO 2018; 8) Haanen 2017; 9) NCCN 2018; 10) Puzanov 2017; 11) Watanabe 2011; 12) NIH-NCI CTCAE 2017; 13) Hershman 2014. (see pages 40-48 for full references).




Skin Rash Practice Guide

Skin rash/alteration: A change in the colour, texture or integrity of the skin.¹⁻¹¹

This practice guide is intended for any rash except for skin changes from radiation reaction. If the rash is in the radiation therapy area, refer to the Skin Reaction to Radiation practice guide.

1. Assess severity of the skin rash (Supporting evidence: 15 guidelines)¹⁻¹⁵

Tell me about the skin rash (e.g. location, onset, what does it look like):¹ _____

What number from 0 to 10 best describes your skin rash where 0="No skin rash" and 10="Worst possible skin rash" ^{1,16}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your skin rash? ^{1,15}	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Is the skin rash on one small part of your body (localized) or does it cover other areas (generalized)? ^{1,3,6,7,12,17}	<10% BSA ^{G1}	<input type="checkbox"/>	10-30% BSA ^{G2}	<input type="checkbox"/>	>30% BSA ^{≥3}	<input type="checkbox"/>
→ Is the skin rash localized or generalized? ^{2,4,5,8,9,11,13,14}			<10% BSA ^{G1}	<input type="checkbox"/>	>10% BSA ^{G≥2}	<input type="checkbox"/>
Do you have any open wounds or blisters? ^{1-8,11,12}	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is the rash moist or weeping? ^{1,12}	No/Dry	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have pain or feel burning at the skin rash area? ^{1-3,6,7,11,13,15}	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Is the rash itchy? ^{1-8,10-14}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does the affected area feel tight or swollen? ^{1,2,4,5,11-13}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Have you experienced a rash like this before? ^{3,9}	No/controlled with treatment	<input type="checkbox"/>			Yes, did not respond to treatment	<input type="checkbox"/>
Does your skin rash affect your daily activities? ^{1-13,15}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
	 1	Mild (Green)	 2	Moderate (Yellow)	 3	Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 14 guidelines)¹⁻¹⁴	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		<input type="checkbox"/> Refer for medical attention immediately. <input type="checkbox"/> Alert clinician if on immunotherapy.	

Legend: → Immune Checkpoint Inhibitor therapy; BSA=Body surface area; NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional comments:

3. Review medications patient is using for skin rash, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 16 guidelines)^{1-15,18}

Current use	Examples of medications for skin rash	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Topical corticosteroids (hydrocortisone, betamethasone, clobetasol propionate) ¹⁻¹⁵		Expert opinion
<input type="checkbox"/>	Antihistamines or antipruritics (hydroxyzine diphenhydramine, cetirizine, loratidine) ^{2-11,13-15,18}		Expert opinion
<input type="checkbox"/>	Oral corticosteroids (prednisone, methylprednisolone) ^{2-9,11-15,18}		Expert opinion
<input type="checkbox"/>	Antibiotics for infection, ^{1,3,4,7,10,12,15} or prophylaxis ^{3,6,14,18}		Likely effective
<input type="checkbox"/>	Prophylaxis: Vitamin K cream ^{3,6,15}		Expert opinion

* Low-dose corticosteroid cream should be used sparingly.^{2,3,10}

4. Review 3 or more self-care strategies (Supporting evidence: 12 guidelines)^{1,3-11,14,15}

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for managing your skin rash? ¹
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have a skin rash? ¹ Reinforce as appropriate.
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding sun and protecting your skin with sunscreen and clothes? ^{1,3-11,14,15}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding skin irritants (e.g. alcohol or perfume based creams, clothes washed in scented laundry soap)? ^{1,3,5-7,9,11,15}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using moisturizing cream on your skin (e.g. urea-based) daily? ^{1,3-8,10,14}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If itchy, are you using oatmeal baths? ^{4,15}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to take warm showers using mild non-scented soap ? Avoid hot water and bathing too long. ^{1,3,6,7,10,14}
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use a cool compress for itchy skin? ^{4,7,15}
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen Specify:
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur ¹

Name	Signature	Date
------	-----------	------




References: 1) BCCA 2016; 2) NCCN 2018; 3) Pinto 2016; 4) CCO 2018; 5) Haanen 2017; 6) Gravalos 2019; 7) Chu 2017; 8) Hryniewicki 2018; 9) Brahmer 2018; 10) Califano 2015; 11) Belum 2016; 12) NCCN 2015; 13) Puzanov 2017; 14) BCCA 2017; 15) Brown 2016; 16) Watanabe 2011; 17) NIH-NCI CTCAE 2017; 18) ONS 2017 (see pages 40-48 for full references).

Skin Reaction to Radiation Practice Guide

Skin reaction/alteration: A change in the colour, texture or integrity of the skin.^{1,2}

1. Assess severity of the skin reaction to radiation (Supporting evidence: 4 guidelines)¹⁻⁴

Site of skin reaction(s)³ _____ Size of skin reaction(s)³ _____

What number from 0 to 10 best describes your skin reaction where 0="No skin reaction" and 10="Worst possible skin reaction" ^{2,3,5}	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your skin reaction? ²	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Is your skin red? ²⁻⁴	None	<input type="checkbox"/>	Faint/dull	<input type="checkbox"/>	Tender/bright, necrotic	<input type="checkbox"/>
Is your skin peeling/flaking? ^{2-4,6}	No/Dry ^{G1}	<input type="checkbox"/>	Patchy, moist ^{G2}	<input type="checkbox"/>	Generalized, moist ^{G3}	<input type="checkbox"/>
Do you have any swelling around the skin reaction area? ²⁻⁴	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, pitting edema	<input type="checkbox"/>
Do you have pain at the skin reaction area? ²⁻⁴	No/Mild 0-3	<input type="checkbox"/>	Moderate 4-6	<input type="checkbox"/>	Severe 7-10	<input type="checkbox"/>
Do you feel itchy at the skin reaction area? ^{1-4,6}	No/Mild ^{G1}	<input type="checkbox"/>	Yes, often ^{G2}	<input type="checkbox"/>	Yes, constant ^{G3}	<input type="checkbox"/>
Do you have any open, draining wounds? ²⁻⁴	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Is there any odour from the skin reaction area? ^{2,3}	No	<input type="checkbox"/>			Yes, strong/foul	<input type="checkbox"/>
Do you have any bleeding? ^{2,3}	No	<input type="checkbox"/>			Yes, from minor trauma	<input type="checkbox"/>
Do you have a fever > 38° C? ²⁻⁴ <input type="checkbox"/> Unsure	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Have you started a new medication? ^{2,3}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Does your skin reaction affect your daily activities? ^{2,3}	No	<input type="checkbox"/>	Yes, some	<input type="checkbox"/>	Yes, a lot	<input type="checkbox"/>
	 1	Mild (Green)	 2	Moderate (Yellow)	 3	Severe (Red)
2. Triage patient for symptom management based on highest severity (Supporting evidence: 2 guidelines)^{3,4}	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 12-24 hours.		<input type="checkbox"/> Refer for medical attention immediately.	

Legend: NCI-CTCAE G1=Grade 1, G2=Grade 2, ≥G3=Grade 3 or higher

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional Comments:

3. Review medications patient is using for skin reaction, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 3 guidelines)²⁻⁴

Current use	Examples of medications for skin reaction to radiation therapy*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Prevention: Calendula ointment ²		Likely effective
<input type="checkbox"/>	Pruritus: Low-dose corticosteroid cream ²⁻⁴		Likely effective
<input type="checkbox"/>	Infection: Silver Sulfadiazine (Flamazine) ^{2,3}		Likely effective
<input type="checkbox"/>	Open areas: Hydrocolloid & hydrogel Dressings ^{3,4}		Expert opinion
<input type="checkbox"/>	Moist desquamation: Silicone Dressings ³		Expert opinion
<input type="checkbox"/>	Infection: Topical antibiotics ²		Expert opinion

*Insufficient evidence to support or refute other topical agents for prevention of skin reaction (i.e., sucralfate cream, ascorbic acid, chamomile cream, almond ointment, polymer adhesive skin sealant). Low-dose corticosteroid cream should be used sparingly.^{2-4,7} Silver sulfadiazine should not be used if allergy to sulfa, history of severe renal or hepatic disease or during pregnancy.³ Hydrocolloid & hydrogel dressings are not advised for infected wounds and wounds with heavy exudate,³ or applied directly prior to treatment.⁴ Emerging evidence for proteolytic enzymes for treatment of skin reaction from radiation.¹ Trolamine (Biafine[®]) and aloe vera are not recommended for radiation skin reaction.²

4. Review 3 or more self-care strategies (Supporting evidence: 4 guidelines)¹⁻⁴

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
			1. What is your goal for managing your skin reaction? ³
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have a skin reaction? ³ Reinforce as appropriate.
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to take lukewarm/tepid showers or baths using mild non-perfumed soap, and patting dry (no rubbing)? ^{1-4,7}
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use non-scented , lanolin-free, water-based creams on intact skin? ^{3,4}
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you wearing loose clothes ? ^{2,3}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding using petroleum jelly , alcohol, and perfumed products? ^{3,4}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you using non-metallic deodorant ? ¹⁻³
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you trying to use an electric razor instead of a wet razor for shaving? Stop shaving if area becomes irritated. ²⁻⁴
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding waxing or other hair removal creams? ³
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding skin creams or gels in the treatment area before treatment ? ^{2,4}
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding wet swim wear in the treatment area? ^{2,3}
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding temperature extremes (e.g. ice pack or heating pad) to the reaction area? Are you trying to protect the treatment area from the sun and the cold ? ²⁻⁴
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If the reaction area is itchy, are you trying to use warm or room temperature normal saline compresses up to 4 times a day ? ³
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you avoiding trauma to the treatment area by not using tape or Band-aids, not rubbing or scratching your skin, and opting to wear loose fitting clothing? ²⁻⁴
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 12-24 hours if no improvement, symptom worsens, or new symptoms occur




Name	Signature	Date
------	-----------	------

References: 1) Chan 2014; 2) ONS 2017; 3) BCCA 2017; 4) Pinto 2016; 5) NlCaN 2015; 6) Watanabe 2011; 7) NIH-NCI CTCAE 2017 (see pages 40-48 for full references).

Sleep Changes Practice Guide

Sleep changes: actual or perceived changes in night sleep resulting in daytime impairment.¹⁻³

1. Assess severity of the sleep changes (Supporting evidence: 3 guidelines)¹⁻³

What number from 0 to 10 best describes how much your sleep changes affect your daytime activities at home and work where 0="No problems" and 10="Worst possible problems" ¹⁻³	1-3	<input type="checkbox"/>	4-6	<input type="checkbox"/>	7-10	<input type="checkbox"/>
Are you worried about your sleep changes? ¹⁻³	No/Some	<input type="checkbox"/>	Yes, very	<input type="checkbox"/>		
Do you have difficulty falling asleep? ¹⁻³	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>	Takes ≥30 min every night	<input type="checkbox"/>
Do you have difficulty staying asleep? ¹⁻³	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>	Takes ≥30 min every night to go to sleep again	<input type="checkbox"/>
Do you have early morning waking when not desired? ¹⁻³	<3 nights/week	<input type="checkbox"/>	3+ nights/week	<input type="checkbox"/>		
How long have these sleep changes been present? ¹⁻³ Describe the sleep pattern change. ¹⁻³	Less than 1 month	<input type="checkbox"/>	More than 1 month	<input type="checkbox"/>		
Did the onset of this problem occur with another issue? ¹⁻³ Describe.	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Are you taking any medicines that affect sleep (e.g. opiates, steroids, sedatives, etc.) ^{1,3}	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>		
Do you have other sleep disorders (e.g., loud snoring, choking/gasping, sleep apnea, restless movement, restless legs)? ¹⁻³	No	<input type="checkbox"/>			Yes	<input type="checkbox"/>
Do you have other symptoms: ¹⁻³ <input type="checkbox"/> fatigue, <input type="checkbox"/> pain, <input type="checkbox"/> nausea, <input type="checkbox"/> anxiety, <input type="checkbox"/> depression, <input type="checkbox"/> hot flashes.	None	<input type="checkbox"/>	Some	<input type="checkbox"/>	Yes, many	<input type="checkbox"/>
	 1 Mild (Green)		 2 Moderate (Yellow)		 3 Severe (Red)	
2. Triage patient for symptom management based on highest severity (Supporting evidence: 3 guideline)¹⁻³	<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications		<input type="checkbox"/> Review self-care. <input type="checkbox"/> Verify medications <input type="checkbox"/> Advise to notify if symptom worsens, new symptoms occur, or no improvement in 2-3 days.		<input type="checkbox"/> Review self-care (If ≥30 minutes see 4.16). <input type="checkbox"/> Verify medication use, if appropriate. <input type="checkbox"/> For other sleep disorders, refer to sleep disorder clinic.	

If patient has other symptoms, did you refer to the relevant practice guide(s)? Please specify:

Additional Comments:

3. Review medications patient is using for sleep changes, including prescribed, over the counter, and/or herbal supplements (Supporting evidence: 2 guidelines)^{1,3}

Current use	Examples of Medications for sleep changes*	Notes (e.g. dose, suggest to use as prescribed)	Evidence
<input type="checkbox"/>	Benzodiazepines - lorazepam (Ativan [®]), diazepam, (Valium [®]), alprazolam (Xanax [®]) ^{1,3}		Expert opinion
<input type="checkbox"/>	Non-benzodiazepine Hypnotics - Zolpidem (Ambien [®]) ^{1,3}		Expert opinion
<input type="checkbox"/>	Tricyclic Antidepressants - Amitriptyline (Elavil [®]) ³		Expert opinion
<input type="checkbox"/>	Neuroleptics - Chlorpromazine (Thorazine [®] , Ormazine [®]) ³		Expert opinion
<input type="checkbox"/>	Herbal supplements (Melatonin, Kava, Valerian) ³		Expert opinion
<input type="checkbox"/>	Melatonin receptor agonists - Ramelteon (Rozerem [®]) ³		Expert opinion
<input type="checkbox"/>	Antipsychotics - Quetiapine (Seroquel [®]) ³		Expert opinion

*Medications for sleep changes should be short term (7-10 days) and depends on side effect profiles of the medicine and the potential for interaction with other current medications; need to balance benefits with harms.^{1,3} Tricyclic antidepressants should be avoided in the elderly.³ Antipsychotics are a last option.³

4. Review 3 or more self-care strategies (Supporting evidence: 3 guidelines)¹⁻³

Patient already uses	Strategy advised/ education provided	Patient agreed to try	Self-care strategies
1.			What is your goal for sleeping (is it realistic e.g. 6 -10 hours sleep/night)? ^{1,3}
2. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What helps when you have problems sleeping? ^{1,3} Reinforce as appropriate.
3. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you kept a sleep diary ? ¹⁻³
4. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you try to go to sleep and wake at the same time each day? ¹⁻³
5. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you get exposed to light soon after waking? ^{1,2}
6. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you try to clear your head early evening (problem solve, write down plan)? ^{1,2}
7. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a 90-minute buffer zone before bedtime (e.g., read, watch TV, crossword puzzle, relax, listen to music, yoga, deep breathing, meditation, guided imagery)? ¹⁻³
8. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you go to bed when you are sleepy ? ¹⁻³ If you can't fall asleep within 20-30 minutes, do you get out of bed and return when sleepy? ¹⁻³
9. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you limit the use of the bedroom for sleep and/or sex ? ¹⁻³
10. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you restrict napping in the daytime? ¹⁻³ If needed, limit to one nap (20-30 minutes) and spend at least four hours awake before bedtime. ²
11. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a comfortable sleep environment ? Suggest removing bedroom clock and avoid computer screens. If noisy or too bright, use ear plugs or eye masks . ¹⁻³
12. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you understand the effect of some medications on sleep ? Provide education. ^{1,3}
13. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you have other symptoms , are they under control? ³
14. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Are you exercising regularly? ¹⁻³
15. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you know what to avoid ? Suggest: limiting caffeine after noon, limit smoking or alcohol, spicy or heavy meals, excessive fluids, intense activities close to bedtime. ¹⁻³
16. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you tried a program like cognitive-behavioural therapy or received personal counseling that provides more in-depth guidance on managing sleep changes? ¹⁻³
17. <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Would more information about your symptoms help you to manage them better? If yes, provide appropriate information or suggest resources.

5. Summarize and document plan agreed upon with patient (check all that apply)

<input type="checkbox"/>	No change, continue with self-care strategies and if appropriate, medication use
<input type="checkbox"/>	Patient agrees to try self-care items #: How confident are you that you can try what you agreed to do (0=not confident, 10=very confident)?
<input type="checkbox"/>	Patient agrees to use medication to be consistent with prescribed regimen. Specify:
<input type="checkbox"/>	Referral (service & date):
<input type="checkbox"/>	Patient agrees to seek medical attention; specify time frame:
<input type="checkbox"/>	Advise to call back in 2-3 days if no improvement, symptom worsens, or new symptoms occur

Name	Signature	Date
------	-----------	------

References: 1) Howell 2012; 2) ONS 2017; 3. BCCA 2014; 4) Watanabe 2011 (see pages 40-48 for full references).

Full list of references

Anxiety

1. Howell D, Keshavarz H, Esplen MJ, et al. *A Pan Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer*. Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology;2015.
2. Oncology Nursing Society. *ONS Symptom Interventions: Anxiety*. 2017.
3. National Comprehensive Cancer Network. *Distress Management (Version 2.2018)*. 2018.
4. Butow P, Price MA, Shaw JM, et al. Clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients: Australian guidelines. *Psychooncology*. 2015;24(9):987-1001.
5. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
6. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
7. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Endocrine*. 2017.
8. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
9. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
10. Haanen J, Carbone F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
11. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
12. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
13. Bradt J, Dileo C, Magill L, Teague A. Music interventions for improving psychological and physical outcomes in cancer patients. *Cochrane Database Syst Rev*. 2016(8):CD006911.

Appetite Loss

1. Oncology Nursing Society. *ONS Symptom Interventions: Anorexia*. 2017.
2. Cancer Care Ontario. *Symptom Management Guide-to-Practice: Loss of Appetite*. Toronto, Ontario 2012.
3. BC Cancer Agency. *Symptom Management Guidelines: ANOREXIA and CACHEXIA*. 2014.
4. Arends J, Bachmann P, Baracos V, et al. ESPEN guidelines on nutrition in cancer patients. *Clin Nutr*. 2017;36(1):11-48.
5. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
6. Haanen J, Carbone F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
7. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
8. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
9. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
10. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.

Bleeding

1. Oncology Nursing Society. *ONS Symptom Interventions: Prevention of Bleeding*. 2019.
2. Cancer Care Nova Scotia. *Guidelines for the Management of Oncologic Emergencies in Adult Patients*. 2014.
3. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.

4. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
5. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
6. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
7. Haanen J, Carbonnel F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
8. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
9. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Enterocolitis*. 2017.
10. Estcourt L, Stanworth S, Doree C, et al. Prophylactic platelet transfusion for prevention of bleeding in patients with haematological disorders after chemotherapy and stem cell transplantation. *Cochrane Database Syst Rev*. 2012(5):CD004269.

Breathlessness/Dyspnea

1. Oncology Nursing Society. *ONS Symptom Interventions: Dyspnea*. 2017.
2. Cancer Care Ontario. *Symptom Management Guide-to-Practice: Dyspnea*. Toronto, Ontario, Canada 2010.
3. BC Cancer Agency. *Dyspnea*. 2014.
4. BC Guidelines. *Chronic heart failure – Diagnosis and management*. Retrieved from http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/chronicheartfailure_full.pdf2015.
5. SIGN. *Management of chronic heart failure*. Retrieved from <http://www.sign.ac.uk/pdf/SIGN147.pdf2016>.
6. American College of Cardiology Foundation & American Heart Association. 2013 ACCF/AHA guideline for the management of heart failure. *Journal of the American College of Cardiology*. 2013;26(16):e147 – e239.
7. European Society of Cardiology. 2016 ESC Guidelines for the diagnosis and treatment of acute and chronic heart failure: The Task Force for the diagnosis and treatment of acute and chronic heart failure of the European Society of Cardiology (ESC) Developed with the special contribution of the Heart Failure Association (HFA) of the ESC. *Eur Heart J*. 2016;37(27):2129-2200.
8. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
9. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
10. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
11. Haanen J, Carbonnel F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
12. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
13. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
14. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
15. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
16. National Heart Foundation. *Guidelines for the prevention, detection and management of chronic heart failure in Australia*. Retrieved from https://www.heartfoundation.org.au/images/uploads/publications/Chronic_Heart_Failure_Guidelines_2011.pdf2011.
17. Canadian Cardiovascular Society. The 2012 Canadian Cardiovascular Society heart failure management guidelines update: focus on acute and chronic heart failure. *Can J Cardiol*. 2013;29(2):168-181.
18. American College of Cardiology, American Heart Association, Heart Failure Society of America. 2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure Society of America. *Circulation*. 2016;134(13):e282-293.

Constipation

1. Oncology Nursing Society. *ONS Symptom Interventions: Constipation*. 2017.
2. Cancer Care Ontario. *Symptom Management Guide-to-Practice: Bowel Care*. 2012.
3. BC Cancer Agency. *Symptom Management Guidelines: Constipation*. 2014.
4. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
5. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
6. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
7. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
8. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Endocrine*. 2017.
9. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
10. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.

Depression

1. Oncology Nursing Society. *ONS Symptom Interventions: Depression*. 2019.
2. National Comprehensive Cancer Network. *Distress Management (Version 2.2018)*. 2018.
3. Howell D, Keshavarz H, Esplen MJ, et al. *A Pan Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer*. Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology;2015.
4. Cancer Care Ontario. *Symptom Management Algorithm: Depression in adults with cancer*. 2019.
5. Butow P, Price MA, Shaw JM, et al. Clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients: Australian guidelines. *Psychooncology*. 2015;24(9):987-1001.
6. Li M, Kennedy EB, Byrne N, et al. Management of Depression in Patients With Cancer: A Clinical Practice Guideline. *J Oncol Pract*. 2016;12(8):747-756.
7. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
8. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
9. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
10. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.

Diarrhea

1. Oncology Nursing Society. *ONS Symptom Interventions: Diarrhea*. 2017.
2. BC Cancer Agency. *Symptom Management Guidelines: Cancer-Related Diarrhea*. 2014.
3. Cancer Care Ontario. *Symptom Management Guide-to-Practice: Bowel Care*. 2012.
4. Schmidt-Hieber M, Bierwirth J, Buchheidt D, et al. Diagnosis and management of gastrointestinal complications in adult cancer patients: 2017 updated evidence-based guidelines of the Infectious Diseases Working Party (AGIHO) of the German Society of Hematology and Medical Oncology (DGHO). *Ann Hematol*. 2018;97(1):31-49.
5. Peterson DE, Boers-Doets CB, Bensadoun RJ, Herrstedt J, Committee EG. Management of oral and gastrointestinal mucosal injury: ESMO Clinical Practice Guidelines for diagnosis, treatment, and follow-up. *Ann Oncol*. 2015;26 Suppl 5:v139-151.
6. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Enterocolitis*. 2017.
7. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.

8. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
9. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
10. Haanen J, Carbone F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
11. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines*. 2015.
12. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
13. Oncology Nursing Society. *ONS Symptom Interventions: Immunotherapy-Induced Diarrhea*. 2017.
14. Califano R, Tariq N, Compton S, et al. Expert Consensus on the Management of Adverse Events from EGFR Tyrosine Kinase Inhibitors in the UK. *Drugs*. 2015;75(12):1335-1348.
15. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
16. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
17. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
18. Lalla RV, Bowen J, Barasch A, et al. MASCC/ISOO clinical practice guidelines for the management of mucositis secondary to cancer therapy. *Cancer*. 2014;120(10):1453-1461.

Fatigue/Tiredness

1. BC Cancer Agency. *Symptom Management Guidelines: CANCER – RELATED FATIGUE AND ANEMIA*. 2014.
2. Howell D, Keshavarz H, Broadfield L, et al. *Pan Canadian Practice Guideline for Screening, Assessment, and Management of Cancer Related Fatigue in Adults Version 2-2015*. Toronto: Canadian Partnership Against Cancer (Cancer Journey Advisory Group) and the Canadian Association of Psychosocial Oncology; 2015.
3. Oncology Nursing Society. *ONS Symptom Interventions: Fatigue*. 2017.
4. National Comprehensive Cancer Network. *Cancer-Related Fatigue (Version 2.2018)*. 2018.
5. Alberta Health Services. *Cancer-Related Fatigue*. 2017.
6. Bennett S, Pigott A, Beller EM, Haines T, Meredith P, Delaney C. Educational interventions for the management of cancer-related fatigue in adults. *Cochrane Database Syst Rev*. 2016;11:CD008144.
7. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
8. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
9. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
10. Haanen J, Carbone F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
11. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
12. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
13. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Endocrine*. 2017.
14. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Liver*. 2017.
15. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.

16. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0.* 2017.
17. Bradt J, Dileo C, Magill L, Teague A. Music interventions for improving psychological and physical outcomes in cancer patients. *Cochrane Database Syst Rev.* 2016(8):CD006911.

Febrile Neutropenia

1. Freifeld AG, Bow EJ, Sepkowitz KA, et al. Clinical practice guideline for the use of antimicrobial agents in neutropenic patients with cancer: 2010 update by the infectious diseases society of america. *Clin Infect Dis.* 2011;52(4):e56-93.
2. National Comprehensive Cancer Network. *Prevention and Treatment of Cancer-Related Infections - Version 1.* 2018.
3. Klastersky J, de Naurois J, Rolston K, et al. Management of febrile neutropaenia: ESMO Clinical Practice Guidelines. *Ann Oncol.* 2016;27(suppl 5):v111-v118.
4. Tam CS, O'Reilly M, Andresen D, et al. Use of empiric antimicrobial therapy in neutropenic fever. Australian Consensus Guidelines 2011 Steering Committee. *Intern Med J.* 2011;41(1b):90-101.
5. Alberta Health Services. *Management of Febrile Neutropenia in Adult Cancer Patients.* 2014.
6. Cancer Care Manitoba (CCMB). *Neutropenia Protocol – Identification and Management of Neutropenic Fever Syndromes.* 2017.
7. Cancer Care Nova Scotia. *Guidelines for the Management of Oncologic Emergencies in Adult Patients.* 2014.
8. Krzyzanowska MK, Walker-Dilks C, Atzema C, et al. Approach to fever assessment in ambulatory cancer patients receiving chemotherapy: a clinical practice guideline. *Curr Oncol.* 2016;23(4):280-285.
9. Taplitz RA, Kennedy EB, Bow EJ, et al. Outpatient Management of Fever and Neutropenia in Adults Treated for Malignancy: American Society of Clinical Oncology and Infectious Diseases Society of America Clinical Practice Guideline Update. *J Clin Oncol.* 2018;36(14):1443-1453.
10. BC Cancer Agency. *Fever and Neutropenia.* 2014.
11. Oncology Nursing Society. *ONS Symptom Interventions: Prevention of Infection.* 2017.
12. National Institute for Health and Clinical Excellence (NICE). *Neutropenic sepsis: prevention and management of neutropenic sepsis in cancer patients.* 2012.
13. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines.* 2015.
14. Flowers CR, Seidenfeld J, Bow EJ, et al. Antimicrobial prophylaxis and outpatient management of fever and neutropenia in adults treated for malignancy: American Society of Clinical Oncology clinical practice guideline. *J Clin Oncol.* 2013;31(6):794-810.
15. Neumann S, Krause SW, Maschmeyer G, et al. Primary prophylaxis of bacterial infections and Pneumocystis jirovecii pneumonia in patients with hematological malignancies and solid tumors : guidelines of the Infectious Diseases Working Party (AGIHO) of the German Society of Hematology and Oncology (DGHO). *Ann Hematol.* 2013;92(4):433-442.
16. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0.* 2017.

Mouth Dryness/Xerostomia

1. BC Cancer Agency. *Xerostomia.* 2014.
2. Cancer Care Ontario. *Symptom Management Guide-to-Practice: Oral Care.* 2012.
3. American Academy of Oral Medicine. AAOM Clinical Practice Statement: Subject: Clinical management of cancer therapy-induced salivary gland hypofunction and xerostomia. *Oral Surg Oral Med Oral Pathol Oral Radiol.* 2016;122(3):310-312.
4. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines.* 2015.
5. Peterson DE, Boers-Doets CB, Bensadoun RJ, Herrstedt J, ESMO Guidelines Committee. Management of oral and gastrointestinal mucosal injury: ESMO Clinical Practice Guidelines for diagnosis, treatment, and follow-up. *Ann Oncol.* 2015;26 Suppl 5:v139-151.
6. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage.* 2011;41(2):456-468.
7. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0.* 2017.
8. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018).* 2018.

9. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
10. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.

Mouth Sores/Stomatitis

1. Oncology Nursing Society. *ONS Symptom Interventions: Mucositis*. 2017.
2. Cancer Care Ontario. *Symptom Management Guide-to-Practice: Oral Care*. 2012.
3. BC Cancer Agency. *Oral Mucositis*. 2014.
4. Peterson DE, Boers-Doets CB, Bensadoun RJ, Herrstedt J, ESMO Guidelines Committee. Management of oral and gastrointestinal mucosal injury: ESMO Clinical Practice Guidelines for diagnosis, treatment, and follow-up. *Ann Oncol*. 2015;26 Suppl 5:v139-151.
5. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines*. 2015.
6. Califano R, Tariq N, Compton S, et al. Expert Consensus on the Management of Adverse Events from EGFR Tyrosine Kinase Inhibitors in the UK. *Drugs*. 2015;75(12):1335-1348.
7. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
8. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
9. Lalla RV, Bowen J, Barasch A, et al. MASCC/ISOO clinical practice guidelines for the management of mucositis secondary to cancer therapy. *Cancer*. 2014;120(10):1453-1461.

Nausea & Vomiting

1. BC Cancer Agency. *Symptom Management Guidelines: Nausea and Vomiting*. 2014.
2. Cancer Care Ontario. *Symptom Management Algorithm: Nausea and Vomiting in Adults with Cancer*. 2019.
3. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines*. 2015.
4. National Comprehensive Cancer Network. *Antiemesis Version 1.2019*. 2019.
5. Roila F, Molassiotis A, Herrstedt J, et al. MASCC/ESMO Antiemetic Guideline 2016 With Updates in 2019. *Ann Oncol*. 2019;27(suppl 5):v119-v133.
6. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
7. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
8. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
9. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
10. Haanen J, Carbone F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
11. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
12. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
13. Oncology Nursing Society. *ONS Symptom Interventions: Chemotherapy-Induced Nausea and Vomiting—Adult*. 2017.
14. Hesketh PJ, Bohlke K, Kris MG. Antiemetics: American Society of Clinical Oncology Clinical Practice Guideline Update Summary. *J Oncol Pract*. 2017;13(12):825-830.
15. Smith LA, Azariah F, Lavender VT, Stoner NS, Bettiol S. Cannabinoids for nausea and vomiting in adults with cancer receiving chemotherapy. *Cochrane Database Syst Rev*. 2015(11):CD009464.
16. Health Canada. Health Canada advises Canadians to exercise caution when taking gabapentin or pregabalin with opioids. 2019; <https://healthykanadians.gc.ca/recall-alert-rappel-avis/hc-sc/2019/71003a-eng.php>.

Pain

1. BC Cancer Agency. *Symptom Management Guidelines: Pain*. 2014.
2. National Comprehensive Cancer Network. *Adult Cancer Pain*. 2019.
3. Oncology Nursing Society. *ONS Symptom Interventions: Acute Pain*. 2019. See also: Sundaramurthi et al. 2017. Cancer-Related Acute Pain: A Systematic Review of Evidence-Based Interventions for Putting Evidence Into Practice. *Clin J Oncol Nurs*. 2017 Jun 1;21(3 Suppl):13-30. doi: 10.1188/17.CJON.S3.13-30.
4. Oncology Nursing Society. *ONS Symptom Interventions: Refractory/Intractable Pain*. 2019. See also Brant et al. 2017. Chronic and Refractory Pain: A Systematic Review of Pharmacologic Management in Oncology. *Clin J Oncol Nurs*. 2017;21(3 Suppl):31-53. Accessed 3 Suppl, 21.
5. Daeninck P, Gagnon B, Gallagher R, et al. Canadian recommendations for the management of breakthrough cancer pain. *Curr Oncol*. 2016;23(2):96-108.
6. Cancer Care Ontario. *Symptom Management Algorithm: Pain in Adults with Cancer* 2018.
7. Oncology Nursing Society. *ONS Symptom Interventions: Breakthrough Pain*. 2019. See also: Brant et al. 2017. Breakthrough Cancer Pain: A Systematic Review of Pharmacologic Management. *Clin J Oncol Nurs*. 2017;21(3 Suppl):71-80.
8. Yamaguchi T, Shima Y, Morita T, Hosoya M, Matoba M, Japanese Society of Palliative M. Clinical guideline for pharmacological management of cancer pain: the Japanese Society of Palliative Medicine recommendations. *Jpn J Clin Oncol*. 2013;43(9):896-909.
9. Oncology Nursing Society. *ONS Symptom Interventions: Chronic Pain*. 2019. See also: Eaton et al. 2017. Nonpharmacologic Pain Interventions: A Review of Evidence-Based Practices for Reducing Chronic Cancer Pain. *Clin J Oncol Nurs*. 2017;21(3 Suppl):54-70.
10. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
11. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
12. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer*. 2017;5(1):95.
13. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
14. Haanen J, Carbone F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol*. 2017;28(suppl_4):iv119-iv142.
15. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med*. 2018;55(4):489-502.
16. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
17. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
18. Bradt J, Dileo C, Magill L, Teague A. Music interventions for improving psychological and physical outcomes in cancer patients. *Cochrane Database Syst Rev*. 2016(8):CD006911.

Peripheral Neuropathy

1. BC Cancer Agency. *Chemotherapy-Induced Peripheral Neuropathy*. 2014.
2. Oncology Nursing Society. *ONS Symptom Interventions: Peripheral neuropathy*. 2019.
3. National Comprehensive Cancer Network. *Adult Cancer Pain*. 2019.
4. Cancer Care Ontario. *Symptom Management Algorithm: Pain in Adults with Cancer* 2018.
5. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Neurologic*. 2017.
6. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol*. 2018;36(17):1714-1768.
7. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.

8. Haanen J, Carbonnel F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol.* 2017;28(suppl_4):iv119-iv142.
9. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
10. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer.* 2017;5(1):95.
11. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage.* 2011;41(2):456-468.
12. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
13. Hershman DL, Lacchetti C, Dworkin RH, et al. Prevention and management of chemotherapy-induced peripheral neuropathy in survivors of adult cancers: American Society of Clinical Oncology clinical practice guideline. *J Clin Oncol.* 2014;32(18):1941-1967.

Skin Rash

1. BC Cancer Agency. *Acneiform Rash*. 2016.
2. National Comprehensive Cancer Network. *Management immunotherapy-related toxicities: Immune Checkpoint Inhibitor-Related Toxicities (Version 1.2018)*. 2018.
3. Pinto C, Barone CA, Girolomoni G, et al. Management of Skin Reactions During Cetuximab Treatment in Association With Chemotherapy or Radiotherapy: Update of the Italian Expert Recommendations. *Am J Clin Oncol.* 2016;39(4):407-415.
4. Cancer Care Ontario. *Immune Checkpoint Inhibitor Toxicity Management: Clinical Practice Guideline*. 2018.
5. Haanen J, Carbonnel F, Robert C, et al. Management of toxicities from immunotherapy: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up. *Ann Oncol.* 2017;28(suppl_4):iv119-iv142.
6. Gravalos C, Sanmartin O, Gurrupide A, et al. Clinical management of cutaneous adverse events in patients on targeted anticancer therapies and immunotherapies: a national consensus statement by the Spanish Academy of Dermatology and Venereology and the Spanish Society of Medical Oncology. *Clin Transl Oncol.* 2019;21(5):556-571.
7. Chu CY, Chen KY, Wen-Cheng Chang J, Wei YF, Lee CH, Wang WM. Taiwanese Dermatological Association consensus for the prevention and management of epidermal growth factor receptor tyrosine kinase inhibitor-related skin toxicities. *J Formos Med Assoc.* 2017;116(6):413-423.
8. Hryniewicki AT, Wang C, Shatsky RA, Coyne CJ. Management of Immune Checkpoint Inhibitor Toxicities: A Review and Clinical Guideline for Emergency Physicians. *J Emerg Med.* 2018;55(4):489-502.
9. Brahmer JR, Lacchetti C, Schneider BJ, et al. Management of Immune-Related Adverse Events in Patients Treated With Immune Checkpoint Inhibitor Therapy: American Society of Clinical Oncology Clinical Practice Guideline. *J Clin Oncol.* 2018;36(17):1714-1768.
10. Califano R, Tariq N, Compton S, et al. Expert Consensus on the Management of Adverse Events from EGFR Tyrosine Kinase Inhibitors in the UK. *Drugs.* 2015;75(12):1335-1348.
11. Belum VR, Benhuri B, Postow MA, et al. Characterisation and management of dermatologic adverse events to agents targeting the PD-1 receptor. *Eur J Cancer.* 2016;60:12-25.
12. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines*. 2015.
13. Puzanov I, Diab A, Abdallah K, et al. Managing toxicities associated with immune checkpoint inhibitors: consensus recommendations from the Society for Immunotherapy of Cancer (SITC) Toxicity Management Working Group. *J Immunother Cancer.* 2017;5(1):95.
14. BC Cancer Agency. *Immune-mediated adverse reaction management guide: Skin*. 2017.
15. Brown J, Su Y, Nelleson D, Shankar P, Mayo C. Management of epidermal growth factor receptor inhibitor-associated rash: a systematic review. *J Community Support Oncol.* 2016;14(1):21-28.
16. Watanabe SM, Nekolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage.* 2011;41(2):456-468.
17. National Institutes of Health: National Cancer Institute. *Common terminology criteria for adverse events (CTCAE) v5.0*. 2017.
18. Oncology Nursing Society. *ONS Symptom Interventions: Skin Reactions*. 2017.

Skin Reaction to Radiation

1. Chan RJ, Webster J, Chung B, Marquart L, Ahmed M, Garantziotis S. Prevention and treatment of acute radiation-induced skin reactions: a systematic review and meta-analysis of randomized controlled trials. *BMC Cancer*. 2014;14:53.
2. Oncology Nursing Society. *ONS Symptom Interventions: Radiodermatitis*. 2017
3. BC Cancer Agency. *Symptom Management Guidelines: Radiation Dermatitis*. 2017.
4. Northern Ireland Cancer Network. *NICaN acute oncology clinical guidelines*. 2015.
5. Watanabe SM, Nikolaichuk C, Beaumont C, Johnson L, Myers J, Strasser F. A multicenter study comparing two numerical versions of the Edmonton Symptom Assessment System in palliative care patients. *J Pain Symptom Manage*. 2011;41(2):456-468.
6. National Institutes of Health, National Cancer Institute. *Common Terminology Criteria for Adverse Events (CTCAE) Version 5.0*. 2017.
7. Pinto C, Barone CA, Girolomoni G, et al. Management of Skin Reactions During Cetuximab Treatment in Association With Chemotherapy or Radiotherapy: Update of the Italian Expert Recommendations. *Am J Clin Oncol*. 2016;39(4):407-415.

Sleep Changes

1. Howell D, Oliver TK, Keller-Olaman S, et al. *A Pan-Canadian Practice Guideline: Prevention, Screening, Assessment and Treatment of Sleep Disturbances in Adults with Cancer*. Toronto: Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology; 2012.
2. Oncology Nursing Society. *ONS Symptom Interventions: Sleep-wake disturbances*. 2019.
3. BC Cancer Agency. *Symptom Management Guidelines: Sleep-Wake Disturbances*. 2014.