ONCOLOGY NURSING SOCIETY

RADIATION THERAPY

PATIENT CARE RECORD

A Tool for Documenting
Nursing Care

Radiation Therapy Patient Care Record: A Tool for Documenting Nursing Care

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Table of Contents

Introduction

In 1990, the Oncology Nursing Society (ONS) Radiation Therapy Special Interest Group (RT SIG) established a work group in an effort to improve and standardize the documentation of nursing care provided to patients receiving radiation therapy. Improved documentation of side effect management and patient education also was a goal of this task. Through the work group's efforts, ONS produced the first edition of ***Radiation Therapy Patient Care Record,*** which has become the standard radiation therapy documentation tool in healthcare facilities across the United States.

In 2000, the RT SIG established a work group to study how nurses use the tool and revise it to better meet the needs of radiation therapy nurses today. The work group sent a survey to all RT SIG members that requested information about how they document nursing care. Responses revealed that, although many institutions continue to use the tool as originally produced, a significant number are using modifications of the original tool. This new edition of the documentation tool incorporates many of the respondents' recommendations. Work group members hope that the new tool will meet the needs of a greater majority of radiation therapy nurses, thus creating an improved standard.

The revised tool is more comprehensive and user-friendly than the original tool. For the first time, users can reproduce the forms in two ways: by printing from the included CD or by photocopying the hard copy contained in the folder. What is more, a fold-out sheet attached to each site-specific care record lists the assessment parameters or criteria users will need to complete the form. Each assessment also includes filling out a sheet that records teaching and instructions as well as detailed medical and social history. These new features will reduce the amount of time needed to document care as well as provide a concise overview of the patient's disease state, treatment program, and educational needs. In an effort to encourage and facilitate nursing research, many of the assessment parameters have been changed to commonly used toxicity criteria.

If you reproduce the Patient Medication Record, any care record, or any teaching and instruction form, you must retain the copyright statement that appears on the bottom of each page.

The work group that developed the revised tool wishes to thank the members of the project core committee for their diligent and thorough efforts, which produced a great tool. The present group hopes this revision will prove to be as well received.

Radiation Therapy Special Interest Group Documentation Project Core Committee (1994)

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Instructions for Using the Radiation Therapy Patient Care Record

The forms in this tool have been designed to give healthcare providers a quick overview of a patient's disease state; the care, medication, and education the patient receives; the side effects the patient experiences; and social information about the patient. The four types of forms the tool includes are

- The initial nursing assessment.
- A patient medication record.
- Radiation therapy patient care records specific to irradiated sites (e.g., abdomen, bone, brain, breast, head and neck, pelvis, skin, thoracic area), with associated toxicity parameters.
- Forms that document the teaching and instructions a patient has received. Each form is specific to an irradiated site.

The sections that follow tell how to complete each type of document. To help you use the records and forms correctly, an example of one completed form follows these instructions.

Initial Nursing Assessment/Database Form

The nurse who will follow the patient through radiation therapy should

- Complete this assessment at the initial visit.
- Complete the demographic information and vital signs portions.
- Record the information about the present illness and past medical history.
- Provide a check mark or brief answer in the areas about social history and review of systems.
- Place an asterisk where additional information is needed, and document this information in the additional space provided.

The nurse completing the initial nursing assessment should sign and date the form.

The Patient Medication Record

Begin by completing the top of the patient medication record: Write the patient's name, his or her medical record or radiation therapy record number (MR#/RT#), and the date on which the first assessment is completed.

Provide the information requested about the patient's allergies and pharmacy.

In the Chemotherapy section of the Patient Medication Record, circle the appropriate letter, N or C, to document chemotherapy that the patient received before starting radiation therapy (neoadjuvant, or N) or chemotherapy that is concurrent (C) with radiation therapy. The form allows you to record pertinent information about the last and future courses of chemotherapy.

In the Medications section, document medication that the patient is currently taking that was started before beginning radiation therapy. Write "PTA" (prior to admission) in the Date column. If the patient begins taking medications during the course of radiation therapy, record the date on which the medication was started. List the dose and route of administration in the appropriate columns. In the Freq column, write how often the patient takes the medication. If the patient stops taking the medication, write in the DC'D column the date it was discontinued. In the Samples column, record information about any sample medication the patient receives, including medication name and dosage. In the last column, document information about refills: the amount dispensed, the number of refills, the date refilled, and your initials.

On the next page of the form, space has been provided to record all medications and IV fluids given during treatment in the radiation department. This includes radioprotectant medications. Any toxicity-related reaction to these medications, such as nausea, vomiting, or a drop in blood pressure, should be recorded in the Response column. This column is ***not*** meant to record the radioprotectant effect of the drug.

The nurse performing the assessment must sign all forms.

Documentation of Radiation Therapy Patient Care

Begin by completing the top of the form. Provide the patient's name, the MR#/RT#, and the date on which the first assessment is performed.

In the lightly shaded area at the top of each site-specific radiation therapy patient care record is an area in which to provide an overview of the patient's disease and treatment status. The data in this section often are buried in other documentation, but nurses need to have it at a glance.

An example is provided using the Patient Care Record for Brain:

Histology Glioblastoma multiforme	**Surgical Procedure** Debulking
Grade/Stage Grade III	**Concurrent Therapy** (Y / (N))
Recurrence (Y / (N))	**Stereotactic XRT** (Y / (N))
Primary or metastasis Primary	**Protocol** none

The Other category that appears in this section on some radiation therapy patient care forms provides a space for critical data about disease or treatment.

Assessment Parameters

For reliability and validity purposes, the work group that developed this tool used established toxicity scales when possible. After reviewing different scales, the group first chose criteria from the National Cancer Institute Common Toxicity Criteria (CTC) Version 2.0. If there were no toxicity criteria for the adverse event in this set, the group selected the Radiation Therapy Oncology Group's (RTOG) Version 2.0 or SOMA Scales criteria. When neither scale offered an appropriate description of the problem, the members selected ratings from the first edition of this tool published by the Oncology Nursing Society or developed a scale indicating absence or presence of the side effect. Citations are noted, indicating which scale is used for each toxicity. **(Please note that all scales do not list descriptors for each of the number ratings. In these instances, a dash, —, is used.)**

In the Assessments section are

- **The Dates and (cGy or Gy) /Fx rows:** In the Dates row, write the date on which the assessment is being performed. In the (cGy or Gy) /Fx (centiGray or Gray/fraction) row, write the cumulative dose followed by the cumulative number of fractions (1,000 cGy/5) for the corresponding assessment day.
- **Subsections about alteration in comfort, nutrition, elimination, skin, mucous membranes, the central nervous system, ventilation, coping, or sexuality and how trauma relates to the risk of falling:** Each "alteration" or trauma subsection cites potential side effects. Consult the assessment parameters or toxicity criteria to assign a score that describes the side effect the patient is experiencing. The Nutrition Alteration subsection includes a space in which to enter the patient's weight. Note that elimination alteration criteria include two scales: one for assessment of a patient with an ostomy, another for assessment of a patient without an ostomy. Record the scores in the column that pertains to the date of the assessment. If an assessment parameter does not provide an appropriate explanation of toxicity, place an asterisk in the box and write a note that describes the toxicity in the area designated by your institution.
- **The Injury, Potential Bleeding/Infection subsection:** In the appropriate cells, write the date blood work was done and the lab values.
- **The Vital Signs subsection:** In this subsection, record the patient's temperature, pulse, and respiration (TPR) rate and blood pressure (BP).
- **The subsection called Other:** This subsection allows you to specify additional information.
- **Box in which to write initials:** In the appropriate box, write your initials to indicate who recorded the data shown in the column above the initials.

Documentation of Teaching and Instructions

Begin by completing the top of the teaching and instructions form: Write the patient's name, MR#/RT#, and the date on which the form is started.

In the Date/Initials column, write the date on which you make an entry. Also write your initials.

Patient education is a process that is ongoing throughout the course of radiation therapy. The teaching and instructions forms, which are specific to the irradiated site, are designed to document teaching as it occurs. Method codes, evaluation codes, and plan codes are listed on each form. Use the method codes to complete the Method column, the evaluation codes to complete the Evaluation column, and the plan codes to complete the Plan column. Provide dates and initials as the form requests. In the Comments column, provide applicable notes.

At the bottom of the form is a box to document social information. Completion of this section provides important information at a glance regarding services that are in place before radiation therapy begins. It also provides useful information regarding transportation issues as well as guidance for prescribing medications that may be required during the radiation treatment course.

The nurse performing the assessments must sign all forms.

RADIATION THERAPY
INITIAL NURSING ASSESSMENT/DATABASE

Patient _____ MR#/RT# _____ Radiation Oncologist _____ Date _____

Diagnosis _____ Prefers Appointment in: AM _____ PM _____

VITAL SIGNS			
Temp:	Pulse:	Resp:	O_2 Sat:
BP:	Height:	Weight:	Pain (0-10) ____Site _____ Describe:_____

HISTORY OF PRESENT ILLNESS
Chief complaint:
Prior radiation therapy? ____No ____Yes, site treated _____ Facility _____ Prior chemotherapy? ____No ____Yes, last treatment _____ Facility _____ Prior hormonal therapy? ____No ____Yes, last treatment _____ Facility _____

CURRENT MEDICATION/ALLERGIES
See Patient Medication Record

PAST MEDICAL HISTORY	
Medical:	Surgical:
Transfusion hx:	Family cancer hx:

SOCIAL HISTORY/HABITS				
Lives with _____			Transportation _____	
Tobacco ____Yes, Pack-year history _____ ____No _____Quit _____			ETOH ____ Yes, freq _____ ____ Quit _____	
Sleep hx:	Insomnia ____Yes ____No None _____	Difficulty getting to sleep _____	Difficulty maintaining sleep _____	Early AM awakening _____

REVIEW OF SYSTEMS				
Constitutional	Fatigue level 0–4 ____	Fevers ___Yes ___No	Night sweats ____Yes ____No	Weight loss ___No ___Yes, ___lb / ___months
Eyes	Vision blurred ___Yes___No	Blind ____Yes ____No	Requires: _____Glasses _____Contacts	
Ears, Nose, Mouth, Throat	Hearing loss ____Yes ___No (Circle) R / L / Both sides Hearing aid(s) ___Yes ___No	Difficulty swallowing ____Yes ____No Dentures ____None ____Upper ____Lower	New lumps _____Yes _____No Location: _____ Dental condition _____Good _____Fair _____Requires consult	
Cardiovascular/ Respiratory	Heart attack ____Yes ____No Stroke ____Yes ____No Angina ___Yes ___No Pacer ___Yes ___No	Cough ___Yes ___No Dyspnea __Yes __ No O_2 @ ____L/min	Orthopnea ___Yes___No # pillows req _____ Hemoptysis ___Yes ___No Other:	

REVIEW OF SYSTEMS (CONTINUED)				
Gastrointestinal	Nausea ___Yes ___No	Ulcers ___Yes ___No	Dyspepsia ___Yes ___No	
	Vomiting ___Yes ___No	Diarrhea ___Yes ___No	Blood in stools ___Yes ___No	
	Constipation ___Yes ___No	Hemorrhoids ____Yes ____No	Feeding tube ____Yes ____No # _____cans of _____/day	
Genitourinary	Dysuria ____Yes ____No	Frequency ____Yes ____No	Urinary incontinence ____Yes Type _____ ____ No	Vaginal itching ____Yes ____No
	Hematuria ____Yes ____No	Urgency ____ Yes ____No		Vaginal discharge ____Yes ____No Describe _____
Integumentary	Rashes _____Yes _____No Location:	Sores ____Yes ____No Location:	Edema ___Yes ___No Location:	Alopecia __Yes __No Location:
	Healing incision _____Yes _____No Location:	Vascular access _____R / L Port / CVC ____ R / L PIC / PICC Last flush: _____	Other:	
Neurologic/ Psychiatric	Oriented x ____ spheres	Headaches __Yes __No	Vertigo ____Yes ____No	Syncope ____Yes ____No
	Memory ____Good ____Fair ____Poor	Depression __Yes __No Seizures _____ No _____Yes, freq _____	Learning preference: ___Written __Verbal___Video Barriers __Yes __No Specify _____	
Allergic/ Immunologic	Autoimmune disorder _____Yes _____No Type _____	Seasonal allergies _____Yes _____No	Other:	
Musculoskeletal	Arthritis ___Yes ___No Location:	Weakness ___Yes ___No	Balance difficulty ___Yes ___No	Assistive device _____
	ROM ____Normal __Decreased in R / L UE __Decreased in R / L LE	At risk of fall ___Yes ___No	ADL ____No limits ____ Needs dressing assistance ____ Needs meal assistance	Other:

Patient has problems with ____Child care ____ Spiritual issues ____ Financial issues ____Transportation
Specify:

_____

_____

Other concerns:

_____

_____

_____

_____

	( )		( )		( )
Signature	Initials	Signature	Initials	Signature	Initials

PATIENT _____ MR#/RT# _____ DATE _____

PATIENT MEDICATION RECORD

Allergies_____

Pharmacy_____ Telephone_____

CHEMOTHERAPY

NEOADJUVANT (N) CONCURRENT (C)		DRUGS	LAST COURSE	FUTURE COURSE(S)	MEDICAL ONCOLOGIST
N	C				
N	C				
N	C				
N	C				

MEDICATIONS

DATE (PTA = prior to admission)	MEDICATION	DOSE	ROUTE	FREQ	DC'D	SAMPLES	REFILLS Amt Dispensed/ # of Refills/ Date Refilled/Initials

( ) ( ) ( )

Signature Initials Signature Initials Signature Initials

MEDICATIONS AND IV FLUIDS GIVEN IN DEPARTMENT DURING TREATMENT

DATE	TIME	MEDICATIONS AND IV FLUIDS	DOSE	ROUTE AND LOCATION	RESPONSE	INITIALS

( ) ( ) ( )

Signature Initials Signature Initials Signature Initials

Sample Patient Care Record

PATIENT Jane Doe MR#/RT# 2224 DATE 9-27-01

RADIATION THERAPY PATIENT CARE RECORD—BRAIN

Histology	Glioblastoma multiforme	**Surgical Procedure**	Debulking
Grade/Stage	Grade III	**Concurrent Therapy (Y / N)**	
Recurrence (Y / N) **Location**		**Stereotactic XRT (Y / N)** **Date**	
Primary or Metastasis	Primary	**Protocol**	none

ASSESSMENTS									
Dates	9/27/01	10/25/01	11/1/01	11/8/01	11/15/01	11/26/01	12/3/01	12/10/01	
(cGy or Gy) / Fx	0 / 0	180 / 1	1060 / 6	1980 / 11	2980 / 16	3780 / 23	4686 / 28	5586 / 33	
Comfort Alteration KPS	60%	60%	60%	60%	50%	50%	50%	50%	
Fatigue	2	2	2	2	3	3	3	3	
Pain Location	head	head	head	head	head	head	head	head	
Pain Intensity	4	3	3	3	3	1	2	0	
Pain Intervention	3	3	3	3	3	3	3	3	
Effectiveness of Pain Intervention	4	4	4	4	4	4	4	4	
CNS Alteration Depressed Level of Consciousness	0	0	0	0	0	0	0	0	
Orientation x _____ Spheres	3	3	3	3	3	3	3	3	
Neuropathy—Motor	2	2	2	2	2	2	2	2	
Ataxia	0	0	0	0	0	0	0	0	
Speech Impairment	0	0	0	0	0	0	0	0	
Seizures	3	0	0	0	0	0	0	0	
Urinary Incontinence	0	0	0	0	0	0	0	0	
Bowel Incontinence	0	0	0	0	0	0	0	0	
Insomnia	0	0	2	2	2	2	2	2	
Sensory Alteration Ocular/Visual—Other	0	0	0	0	0	0	0	0	
Middle Ear/Hearing	0	0	0	0	0	0	0	0	
Nutrition Alteration Anorexia	0	0	1	2	2	1	0	1	
Nausea	0	0	1	1	1	0	0	0	
Vomiting	0	0	0	0	0	0	0	0	
Dyspepsia/Heartburn	0	0	0	2	1	1	0	1	
Weight	145	145	143	140	140	140	139	140	
Skin Alteration Skin Sensation	0	0	0	0	1	1	1	1	
Radiation Dermatitis	0	0	0	0	1	1	2	2	
Alopecia	0	0	0	0	1	2	2	2	
Mucous Membrane Alteration Thrush	0	0	0	0	1	0	0	0	
Emotional Alteration Coping	1	0	0	0	0	0	0	0	
Injury, Potential Bleeding/Infection Date	9/27/01	10/25/01	11/1/01	11/8/01	11/15/01	11/26/01	12/3/01	12/10/01	
WBC	10.2	9.8		15.4		23.3		20.2	
Hemoglobin/Hematocrit	14.3 / 43.2	14 / 43		13 / 40		14 / 42.6		14 / 43	
Platelets		121,000							
Blood Sugar		90	90	100	100	96	96	96	
Vital Signs TPR	99.4 80/20				98 72/20			98 72/20	
BP	132/86				130/70			140/80	
Other									
INITIALS	VHP	VHP	VHP	VHP	VHP	VHP	VHP	VHP	

Assessment Parameters and Common Toxicity Criteria
Radiation Therapy Patient Care Record—Brain

COMFORT ALTERATION

Karnofsky Performance Score (KPS)

100%	Normal, no complaints
90%	Can perform normal activity, minor signs of disease
80%	Can perform normal activity with effort, some signs of disease
70%	Cannot do active work, but can care for self
60%	Requires assistance, but can meet most needs with assistance
50%	Requires considerable assistance and frequent medical care
40%	Disabled, requires special care
30%	Severely disabled, hospitalization indicated
20%	Very sick, supportive hospitalization needed
10%	Moribund, fatal processes progressing rapidly

Fatigue (ONS scale)

1	No fatigue
2	Mild fatigue
3	Moderate fatigue
4	Extreme fatigue
5	Worst fatigue

Pain Location

Write, in the box, the location of pain.

Pain Intensity

Record the patient's subjective rating of degree of pain, with ratings ranging from 0 (no pain) to 10 (severe pain).

Pain Intervention[c]

0	None
1	Over-the-counter medications
2	Nonsteroidal anti-inflammatory agents or non-opioids
3	Opioids
4	Adjuvant medication (e.g., neuroleptics [amitriptyline, carbamazepine])
5	Complementary and/or alternative methods

Effectiveness of Pain Intervention[c]

0	No relief
1	Pain relieved 25%
2	Pain relieved 50%
3	Pain relieved 75%
4	Pain relieved 100%

CNS ALTERATION

Depressed Level of Consciousness[a]

0	Normal
1	Somnolence or sedation not interfering with function
2	Somnolence or sedation interfering with function, but not interfering with activities of daily living
3	Obtundation or stupor; difficult to arouse; interfering with activities of daily living
4	Coma

Orientation[c]

Oriented x _____ spheres (person, place, time)

Neuropathy—Motor[a]

0	Normal
1	Subjective weakness but no objective findings
2	Mild objective weakness interfering with function, but not interfering with activities of daily living
3	Objective weakness interfering with activities of daily living
4	Paralysis

Ataxia[c]

0	Absent
1	Present

Speech Impairment (e.g., dysphasia or aphasia)[a]

0	Normal
1	—
2	Awareness of receptive or expressive dysphasia, not impairing ability to communicate
3	Receptive or expressive dysphasia, impairing ability to communicate
4	Inability to communicate

Seizures[a]

0	None
1	—
2	Seizure(s) self-limited and consciousness is preserved
3	Seizure(s) in which consciousness is altered
4	Seizures of any type which are prolonged, repetitive, or difficult to control (e.g., status epilepticus, intractable epilepsy)

Urinary Incontinence[c]
0 Absent
1 Present

Bowel Incontinence[c]
0 Absent
1 Present

Insomnia[a]
0 Normal
1 Occasional difficulty sleeping not interfering with function
2 Difficulty sleeping interfering with function, but not interfering with activities of daily living
3 Frequent difficulty sleeping, interfering with activities of daily living
4 —

SENSORY ALTERATION

Ocular/Visual—Other (Specify, ____)[a]
0 Normal
1 Mild
2 Moderate
3 Severe
4 Unilateral or bilateral loss of vision (blindness)

Middle Ear/Hearing[a]
0 Normal
1 Serous otitis without subjective decrease in hearing
2 Serous otitis or infection requiring medical intervention; subjective decrease in hearing; rupture of tympanic membrane with discharge
3 Otitis with discharge, mastoiditis or conductive hearing loss
4 Necrosis of the canal soft tissue or bone

NUTRITION ALTERATION

Anorexia[a]
0 None
1 Loss of appetite
2 Oral intake significantly decreased
3 Requiring IV fluids
4 Requiring feeding tube or parenteral nutrition

Nausea[a]
0 None
1 Able to eat
2 Oral intake significantly decreased
3 No significant intake, requiring IV fluids
4 —

Vomiting[a]
0 None
1 1 episode in 24 hours over pretreatment
2 2–5 episodes in 24 hours over pretreatment
3 ≥ 6 episodes in 24 hours over pretreatment; or need for IV fluids
4 Requiring parenteral nutrition; or physiologic consequences requiring intensive care; hemodynamic collapse

Dyspepsia and/or Heartburn[a]
0 None
1 Mild
2 Moderate
3 Severe
4 —

SKIN ALTERATION

Skin Sensation[b]
0 No problem
1 Pruritus
2 Burning
3 Painful

Radiation Dermatitis[a]
0 None
1 Faint erythema or dry desquamation
2 Moderate to brisk erythema or patchy moist desquamation, mostly confined to skin folds and creases; or moderate edema
3 Confluent moist desquamation ≥ 1.5 cm diameter and not confined to skin folds; pitting edema
4 Skin necrosis or ulceration of full-thickness dermis; may include bleeding not induced by minor trauma or abrasion

Alopecia[a]
0 Normal
1 Mild hair loss
2 Pronounced hair loss
3 —
4 —

MUCOUS MEMBRANE ALTERATION

Thrush[c]

0	Absent
1	Present

EMOTIONAL ALTERATION

Coping[c]

0	Effective
1	Ineffective

The cited parameters were established by
[a]National Cancer Institute (NCI) Common Toxicity Criteria, Version 2.0
[b]Radiation Therapy Oncology Group (RTOG), Toxicity Criteria, Version 2.0 or the RTOG SOMA Scales
[c]Oncology Nursing Society Radiation Documentation Tool Workgroup.

Sample Teaching and Instructions Form

PATIENT JANE DOE MR#/RT# 6224 DATE 1/21/01

TEACHING AND INSTRUCTIONS—BRAIN

	DATES/ INITIALS	METHOD	EVALUATION	PLAN	COMMENTS
General Care Nutrition	9/27/01 whp	B/C	V	LO	Eating Hints
Social Service	9/27/01 whp	C	V	LO	No insurance
Discharge Care	10/3/01 whp	B	V	RC	
Referrals	10/3/01 whp	B	V	RC	VNA
Site-Specific Simulation	9/27/01 whp	B/C	R	RC	Radiation therapy and You
Initial Treatment	9/27/01 whp	A	R	RC	ANXIOUS
Side Effects	9/27/01 whp	B/C	R	RC	Radiation therapy and You
Fatigue Management	9/27/01 whp	B/C	R	RC	Radiation therapy and You
Oral Management	9/27/01 whp	B/C	R	RC	oral care handouts
Pain Intervention	9/27/01 whp	B	V	LO	
Steroid Management	10/25/01 whp	B	R	RC	
Antiseizure Medication Management	9/27/01 whp	B	V	LO	
Skin Care	9/27/01 whp	B/C	V	LO	skin care guidelines
Hair Care	9/27/01 whp	B/C	V	LO	hair care guidelines
Safety Issues	9/27/01 whp	B	V	LO	
Prevention/Other Smoking Cessation	9/27/01 whp		NR		will continue to approach
Seizure Precautions	9/27/01 whp	B	V	RC	
Falls/Safety Measures	9/27/01 whp	B	V	RC	

Method Codes
A = Personal session
B = Family conference
C = Booklet (specify)
D = Demonstration
E = Audio/video resource

Evaluation Codes
UE = Unable to evaluate (explain)
V = Verbalizes concept accurately
D = Demonstrates skill accurately
R = Needs review
NR = Not receptive to learning at this time (specify)

Plan Codes
RC = Reinforce concept
RD = Return demonstration
LO = Learning objective met
RF = Referral to other health care givers (specify)

SOCIAL INFORMATION	
Lives With (specify relationships)	Husband and 3 children
Agency in Home	VNA
Durable Medical Equipment in Home	none
Transportation	husband to bring her
Prescription Coverage	none
Other	

Signature Initials | Signature ( ) Initials | Signature ( ) Initials

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