Cancer Patient Navigation Intake Form – demographic information

Nav Name		NavID		Date navigation initiated		Type of Navigation (drop down)
Referred by				Date of Referral		Screening & Diagnostic Treatment Survivorship
Client ID #						

First Name		MI		Last Name		Gender (drop down)	☐Male ☐Female ☐Transgender
Date of Birth		Marital Status (drop down)	☐Married ☐Never married ☐Widowed		☐Divorced ☐Not living with partner/spouse ☐Partnered		

Street Address		City		State		Zip	(jump to zip first then have city and state populate)
Mailing Address		City		State		Zip	
Temp Address		City		State		Zip	

Phone 1	**Phone 1:** **Contact Name:** ☐Okay to leave message ☐Okay to identify self ☐Primary contact number	Phone 2	**Phone 2:** **Contact Name:** ☐Okay to leave message ☐Okay to identify self ☐Primary contact number	Other (email, fax)	
Notes		**Notes**		**Notes**	

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Hispanic Origin	☐ Yes ☐ No

Race (check all that apply)

- ☐ Alaska Native
- ☐ African American
- ☐ American Indian
- ☐ Arab/Arabian (Middle East)
- ☐ Asian/East Indian
- ☐ Asian - Other
- ☐ Black - Other
- ☐ Cambodian
- ☐ Caribbean
- ☐ Central American
- ☐ Chamorro
- ☐ Chinese
- ☐ Chuukese
- ☐ Fijian
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Kosraean
- ☐ Laotian
- ☐ Malaysian
- ☐ Maori
- ☐ Marshallese
- ☐ Melanesian - Other
- ☐ Mexican
- ☐ Micronesian - Other
- ☐ Native Hawaiian
- ☐ Okinawan
- ☐ Palauan
- ☐ Pohnpeian
- ☐ Polynesian - Other
- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Samoan
- ☐ South American
- ☐ Tahitian
- ☐ Taiwanese
- ☐ Thai
- ☐ Tokelauan
- ☐ Tongan
- ☐ Vietnamese
- ☐ White/Caucasian
- ☐ Yapese

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Primary Language (drop down)	
☐English ☐Spanish Chinese (2 level drop down box) ☐Mandarin ☐Cantonese Filipino (2 level drop down box) ☐Tagalog ☐Ilocano ☐Visayan ☐Other: specify_____	☐Hawaiian ☐Japanese ☐Korean Micronesian (2 level drop down box) ☐Chuukese ☐Kosraean ☐Marshallese ☐Pohnpeian ☐Yapese ☐Samoan ☐Tongan ☐Vietnamese ☐Other (Specify:_____)

Education (drop down menu)	
☐Refused to answer ☐Primary education only ☐No formal education ☐Some HS/secondary education ☐HS Diploma/GED/Other secondary education	☐Some college/vocational school/other post-secondary education ☐Completed college/vocational school/other post-secondary education ☐Post-college/graduate school

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Household size # of people	**Household Income (Drop down)**		**Employed (drop down)**	
☐ Live Alone _____	☐ Less than $10K	☐ $40K to $49,999	☐ Full-time	☐ Self-employed
☐ Live w/Family_____	☐ $10K to $19,999	☐ $50K or more	☐ Part-time	☐ Retired
☐ Live w/Friend_____	☐ $20K to $29,999	☐ Refuse to answer	☐ Unemployed	☐ Student
☐ Other_____	☐ $30K to $39,999			☐ On Medical Leave
☐ Refuse to answer				

Caregiver support?	**Supporter name(s)**	**Relationship**	**Contact #**	**Supporter Instructions**
☐ Yes				
☐ No				

Medical Team	**None**	**Name of Health Care Professional**	**Facility**	**Contact Person Name**	**Phone #**	**Fax#**
Primary Care Physician						
Medical Oncologist						
Radiation Oncologist						
Surgeon						
Social Worker/Case Manager						

Medical Insurance Status	**Medical Insurance**	**Company Name**	**Policy #**	**Effective Date**
☐ Yes	Primary			
☐ No		Contact name/number:		
☐ Pending **(LINK to task list/calendar)**	Secondary			
		Contact name/number:		
Notes:				

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Family Cancer History	☐ **No known family history**	
Relative	**Cancer Site**	**Other information (cured, remission, watchful waiting, active)**

✓	**Diagnosed co-morbidities**	✓	**Diagnosed Co-morbidities**
	No Co-morbidities		Heart problems
	Arthritis/rheumatism		High blood pressure
	Alcohol problem		Infertility/low fertility
	Bladder control problems		Insomnia/sleep problems
	Bowel function issues		Kidney problems (e.g., kidney stones)
	Breathing/lung problems (asthma, emphysema, COPD, TB)		Liver problems
	Behavior health concerns		Obesity/Overweight
	Cholesterol		Stroke
	Diabetes		Sexual dysfunction
	Drug problem		Thyroid problems
	Epilepsy (seizures, convulsions)		Ulcers, digestion or other stomach problems
	Gallbladder problems		Underweight
	Habitual tobacco user (not including ceremonial use)		Other: please specify (free text field)

Journey on the Cancer Care Continuum – Screening Journey

Patient Cancer History	☐ **Never had cancer**	
Date of diagnosis	**Cancer Site**	**Outcome (drop down)**
		Cured Remission Watchful Waiting Active Treatment failure
Other Information		

Abnormal Screening Results		
Type (drop down)	Date of abnormal/suspicious findings	Date of diagnostic testing
CA-125 Colonoscopy Digital Rectal Exam FOBT Mammogram Pap test PSA Skin checks		

Screening Test				
Type	Screening status (drop down)	Date of Screening	Outcome	Date of next screening
Colon Cancer Screening	☐ Need ☐ Up to date		☐ Didn't get screened ☐ Suspicious finding ☐ Negative Date: _____	
Breast Cancer Screening	☐ Need ☐ Up to date		☐ Didn't get screened ☐ Suspicious finding ☐ Negative Date: _____	

Cervical Cancer Screening	☐ Need ☐ Up to date		☐ Didn't get screened ☐ Negative ☐ Suspicious finding Date: _____	
Skin Cancer Screening	☐ Need ☐ Up to date		☐ Didn't get screened ☐ Negative ☐ Suspicious finding Date: _____	
Prostate Cancer Screening	☐ Need ☐ Up to date		☐ Didn't get screened ☐ Negative ☐ Suspicious finding Date: _____	

Journey on the Cancer Care Continuum – Treatment Journey

Patient Cancer History	☐ **Never had cancer**	
Date of diagnosis	**Cancer Site**	**Outcome (drop down)**
		Cured Remission Watchful Waiting Active Treatment failure
Other Information		

Cancer Status	Date of Diagnosis	Diagnosing Doctor
☐ Diagnosed with Cancer ☐ Not diagnosed with Cancer ☐ Cancer diagnosis not available		

Cancer Site	(drop down)	Histology	(drop down)			
Cancer Stage		Stage (drop down)	Substage (drop down)	T (drop down)	N (drop down)	M (drop down)
☐ No staging information available ☐ Cancer is not staged ☐ Other staging system (Specify:_____)		0 I II III IV	A B C	T0 Tis T1 T2 T3 T4	N0 N1 N2 N3	M0 M1

Date of Initial Treatment		Type of Initial Treatment (check boxes)	☐ Surgery ☐ Chemotherapy ☐ Radiation	☐ Hormone ☐ Other (specify:) ☐ Combination of therapies (specify:)
Treatment Plan				

Dates of Missed Appointment (space for 10 missed appts)	Reason for Missed Appointment (check boxes)	
	☐ No show ☐ No transportation ☐ Feeling sick ☐ No treatment available (e.g., machine broken, run out of meds)	☐ Unaware of appointment ☐ Confusion of dates ☐ Other:

Date of Treatment Plan Completion		Treatment Plan Outcome (check boxes)	☐ No evidence of disease ☐ Treatment Failure ☐ Treatment on-going/maintenance ☐ Watchful Waiting

Navigator Interactions – Actions taken with or on behalf of the client

(up to 100 interactions allowed and one entry per interaction)

Date of interaction		Progress Notes	
Time started			
Total time spent during this interaction (drop down)	☐ 1 to 5 minutes ☐ 6 to 15 minutes ☐ 16 to 30 minutes ☐ 31 to 45 minutes ☐ 46 to 60 minutes ☐ >60 minutes—Specify time_____	Transportation Schedules	
Method of interaction (drop down)	☐ No contact ☐ In-Person ☐ Telephone ☐ Letter/postcard mail out ☐ Teleconference ☐ Email ☐ Fax ☐ Online Chat ☐ Working on issues	Treatment Schedules	
Person interacted with (check all that apply)	☐ Patient ☐ Family and/or friend ☐ Healthcare staff/provider ☐ Social services/community org rep ☐ Other: Specify	Client Communications	

Task List

Date	Task	Completed? (drop down)
		☐ Yes ☐ No

Navigator Interactions – Actions taken with or on behalf of the client

Navigator Barriers (check all that apply)		
☐ No barriers identified/addressed **System barriers** ☐ No established primary care ☐ Transportation (on-island) ☐ Location of health care (off-island) ☐ Housing during treatment ☐ System problems scheduling care ☐ System problems coordinating care ☐ Lack of access to a specialist ☐ System culture and practices ☐ Staff beliefs and attitudes	**Personal barriers** ☐ Financial Difficulties ☐ Difficult access to appropriate food ☐ Disability/comorbidity ☐ Treatment side effects ☐ Unable to care for self at home ☐ Costs: health care ☐ Costs: medication/equipment ☐ Employment issues ☐ Internal psychology (anxiety) ☐ Habitual unhealthy lifestyle ☐ External psychosocial (isolated) ☐ Health literacy/lack of information ☐ Language ☐ Cultural/personal beliefs and attitudes	**Family barriers** ☐ Childcare/family care issues ☐ Housing ☐ Other barrier: Specify:_____)

Navigator Action (check boxes)	
	☐ Assessment of patient needs ☐ Introduction to Navigation Services ☐ Coordinate health care appointment logistics ☐ Discuss diagnosed disease and its treatment ☐ Coordinate education ☐ Educate patient ☐ Coordinate health care coverage ☐ Assist with filling Rx or medical equipment request ☐ Coordinate social services ☐ Link to community organization ☐ Clinical trials notification ☐ Confirm patient status/maintain relationship

Survivorship Referral	Referred (drop down)	Date Referred
Referred to Survivorship Program?	☐ Yes ☐ No	
Enrolled in survivorship program?	☐ Yes ☐ No	

Hospice Referral	Referred (drop down)	Date Referred
Referred to Hospice?	☐ Yes ☐ No	
Enrolled in hospice?	☐ Yes ☐ No	

Clinical Trial Referral	(drop down)
Informed about clinical trials	☐ Yes ☐ No
Patient initiated clinical trials process	☐ Yes ☐ No
Patient enrolled in clinical trials	☐ Yes ☐ No

Case Outcomes

Date Navigation Completed	Case Closeout (drop down)	
	☐ Barrier resolved ☐ Treatment plan completed ☐ Both	☐ Patient withdrew from program ☐ Patient lost to follow-up ☐ Died

Case Notes		(limit 2 fields. If more than 2 dates, open up a new case)
Date		
Date		