**London Holistic Needs Assessment**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | For each item below, please select **yes** or **no** if they have been a concern for you during the last week, including today. Please also select **discuss** if you wish to speak about it with your health professional.  Choose not to complete the assessment today by selecting this box | | | | | | | |
| Date: | | | Click here to enter text. | **Practical concerns** | **Yes** | **No** | **Discuss** | **Physical concerns** | **Yes** | **No** | **Discuss** |
| Caring responsibilities |  |  |  | High temperature |  |  |  |
| Name: | | | Click here to enter text. | Housing or finances |  |  |  | Wound care |  |  |  |
| Transport or parking |  |  |  | Passing urine |  |  |  |
| Hospital/NHS number: | | | Click here to enter text. | Work or education |  |  |  | Constipation or diarrhoea |  |  |  |
| Information needs |  |  |  | Indigestion |  |  |  |
| Please **select the number** that best describes the overall level of distress you have been feeling during the last week, including today: | | | | Difficulty making plans |  |  |  | Nausea and/or vomiting |  |  |  |
| Grocery shopping |  |  |  | Cough |  |  |  |
| Preparing food |  |  |  | Changes in weight |  |  |  |
| Bathing or dressing |  |  |  | Eating or appetite |  |  |  |
| 10 |  | **Extreme distress** | | Laundry/housework |  |  |  | Changes in taste |  |  |  |
| 9 |  |  | | **Family concerns** |  |  |  | Sore or dry mouth |  |  |  |
| 8 |  |  | | Relationship with children |  |  |  | Feeling swollen |  |  |  |
| 7 |  |  | | Relationship with partner |  |  |  | Breathlessness |  |  |  |
| 6 |  |  | | Relationship with others |  |  |  | Pain |  |  |  |
| 5 |  |  | | **Emotional concerns** |  |  |  | Dry, itchy or sore skin |  |  |  |
| 4 |  |  | | Loneliness or isolation |  |  |  | Tingling in hands or feet |  |  |  |
| 3 |  |  | | Sadness or depression |  |  |  | Hot flushes |  |  |  |
| 2 |  |  | | Worry, fear or anxiety |  |  |  | Moving around/walking |  |  |  |
| 1 |  |  | | Anger, frustration or guilt |  |  |  | Fatigue |  |  |  |
| 0 |  | **No distress** | | Memory or concentration |  |  |  | Sleep problems |  |  |  |
|  |  |  | | Hopelessness |  |  |  | Communication |  |  |  |
|  | | | | Sexual concerns |  |  |  | Personal appearance |  |  |  |
| **For health professional use** | | | | **Spiritual concerns** |  |  |  | Other medical condition |  |  |  |
| Date of diagnosis: | | | Click here to enter text. | Regret about the past |  |  |  |  |  |  |  |
| Diagnosis: | | | Click here to enter text. | Loss of faith or other spiritual concern |  |  |  |  |  |  |  |
| Pathway point: | | | Click here to enter text. | Loss of meaning or purpose in life |  |  |  |  |  |  |  |

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**Care Plan**

During my holistic needs assessment, these issues were identified and discussed:

|  |  |  |  |
| --- | --- | --- | --- |
| **Preferred name:** Click here to enter text. | | | **Hospital/NHS number:** Click here to enter text. |
|  | | | |
| **Number** | **Issue** | **Summary of discussion** | **Actions required/by (name and date)** |
| Example | Breathlessness | Possible causes identified  Coping strategies discussed  Printed information provided | Referral to anxiety management programme; CNS to complete by 24th Dec |
| 1 | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 2 | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 3 | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| 4 | Click here to enter text. | Click here to enter text. | Click here to enter text. |
|  |  |  |  |
| Other actions/outcomes e.g. additional information given, health promotion, smoking cessation, ‘My actions’:  Click here to enter text. | | | |
|  |  |  |  |
| **Signed (patient):** Click here to enter text. | | | Date: Click here to enter text. |
| **Signed (healthcare professional):** Click here to enter text. | | | Date: Click here to enter text. |
|  |  |  |  |
| **For health professional use** | | | |
| Date of diagnosis: Click here to enter text. | | Diagnosis: Click here to enter text. | Pathway point: Click here to enter text. |