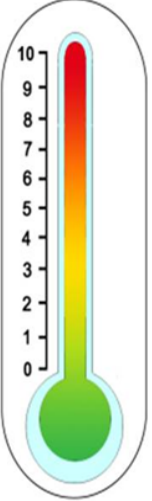


Pan-London Holistic Needs Assessment

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 healthcare professional. Choose not to complete the assessment today by selecting this box.

Date:		Practical concerns	Yes	No	Discuss	Physical concerns	Yes	No	Discuss		
Name:		Caring responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High temperature	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hospital / NHS number:		Housing or finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wound care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Please select the number that best describes the overall level of distress you have been feeling during the last week, including today: 10 <input type="checkbox"/> Extreme distress 9 <input type="checkbox"/> 8 <input type="checkbox"/> 7 <input type="checkbox"/> 6 <input type="checkbox"/> 5 <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> No distress		Transport or parking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Passing urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Work or education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation or diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Information needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Difficulty making plans	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea and/or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Preparing food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Bathing or dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating or appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Laundry/housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Changes in taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
				Family concerns				Sore or dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Relationship with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling swollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with partner	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Breathlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Relationship with others	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Emotional concerns						Dry, itchy or sore skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Loneliness or isolation	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Tingling in hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sadness or depression	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Worry, fear or anxiety	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Moving around/walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anger, frustration or guilt	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Memory or concentration	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
For health professional use		Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Sexual concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Personal appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
		Spiritual concerns				Other medical condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Date of diagnosis:		Regret about the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Diagnosis:		Loss of faith or other spiritual concern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
Pathway point:		Loss of meaning or purpose in life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Care Plan

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

Preferred name:

Hospital/NHS number:

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 24 th Dec
1			
2			
3			
4			

Other actions/outcomes e.g. additional information given, health promotion, smoking cessation, 'My actions':

Signed (patient):	Date:
Signed (healthcare professional):	Date:

For healthcare professional use		
Date of diagnosis:	Diagnosis:	Pathway point: