CANCER RELIEF GIBRALTAR

FULL NAME: __________________________ DOB: ________ CRC #: _____

SPARC – Sheffield Profile for Assessment and Referral for Care SPARC -45 v1.1

Assessment – Date & Time:		**RGN:**	

COMMUNICATION AND INFORMATION ISSUES

1. Have you been able to talk to any of the following people about your condition?	**Yes**	**No**
a. Your doctor	☐	☐
b. Community nurse	☐	☐
c. Hospital nurse	☐	☐
d. Religious advisor	☐	☐
e. Social worker	☐	☐
f. Family	☐	☐
g. Other people (please specify)	☐	☐

PHYSICAL SYMPTOMS: **NOT AT ALL = 0, A LITTLE BIT = 1, QUITE A BIT = 2, VERY MUCH = 3**

In the past month, have you been distressed or bothered by:	**0**	**1**	**2**	**3**	**Comments**
2. Pain?	☐	☐	☐	☐	
3. Loss of memory?	☐	☐	☐	☐	
4. Headache?	☐	☐	☐	☐	
5. Dry mouth?	☐	☐	☐	☐	
6. Sore mouth?	☐	☐	☐	☐	
7. Shortness of breath?	☐	☐	☐	☐	
8. Cough?	☐	☐	☐	☐	
9. Feeling sick (nausea)?	☐	☐	☐	☐	
10. Being sick (vomiting)?	☐	☐	☐	☐	
11. Bowel problems (e.g. constipation, diarrhoea, incontinence)?	☐	☐	☐	☐	
12. Bladder problems (urinary incontinence)?	☐	☐	☐	☐	
13. Feeling weak?	☐	☐	☐	☐	
14. Feeling tired?	☐	☐	☐	☐	
15. Problems sleeping at night?	☐	☐	☐	☐	
16. Feeling sleepy during the day?	☐	☐	☐	☐	
17. Loss of appetite?	☐	☐	☐	☐	
18. Changes in your weight?	☐	☐	☐	☐	
19. Problems with swallowing?	☐	☐	☐	☐	
20. Being concerned about changes in your appearance?	☐	☐	☐	☐	
21. Feeling restless and agitated?	☐	☐	☐	☐	
22. Feeling that your symptoms are not controlled?	☐	☐	☐	☐	

PSYCHOLOGICAL SYMPTOMS: **NOT AT ALL = 0, A LITTLE BIT = 1, QUITE A BIT = 2, VERY MUCH = 3**

In the past month, have you been distressed or bothered by:	**0**	**1**	**2**	**3**	**Comments**
23. Feeling anxious?	☐	☐	☐	☐	
24. Feeling as if you are in a low mood?	☐	☐	☐	☐	
25. Feeling confused?	☐	☐	☐	☐	
26. Feeling as if you are unable to concentrate?	☐	☐	☐	☐	
27. Feeling lonely?	☐	☐	☐	☐	
28. Feeling that everything is an effort?	☐	☐	☐	☐	
29. Feeling that life is not worth living?	☐	☐	☐	☐	
30. Thoughts about ending it all?	☐	☐	☐	☐	
31. The effect of your condition on your sexual life?	☐	☐	☐	☐	

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RELIGIOUS & SPIRITUAL ISSUES:	NOT AT ALL = 0, A LITTLE BIT = 1, QUITE A BIT = 2, VERY MUCH = 3				
In the past month, have you been distressed or bothered by:	**0**	**1**	**2**	**3**	**Comments**
32. Worrying thoughts about death or dying?	☐	☐	☐	☐	
33. Religious or spiritual needs not being met?	☐	☐	☐	☐	
INDEPENDENCE & ACTIVITY ISSUES:	**NOT AT ALL = 0, A LITTLE BIT = 1, QUITE A BIT = 2, VERY MUCH = 3**				
In the past month, have you been distressed or bothered by:	**0**	**1**	**2**	**3**	**Comments**
34. Losing your independence	☐	☐	☐	☐	
35. Changes in your ability to carry out your usual daily activities such as washing, bathing or going to the toilet	☐	☐	☐	☐	
36. Changes in your ability to carry out your usual household tasks such as cooking for yourself or cleaning the house	☐	☐	☐	☐	
FAMILY & SOCIAL ISSUES:	**NOT AT ALL = 0, A LITTLE BIT = 1, QUITE A BIT = 2, VERY MUCH = 3**				
In the past month, have you been distressed or bothered by:	**0**	**1**	**2**	**3**	**Comments**
37. Feeling that people do not understand what you want?	☐	☐	☐	☐	
38. Worrying about that effect that your illness is having on your family or other people?	☐	☐	☐	☐	
39. Lack of support from your family or other people?	☐	☐	☐	☐	
40. Needing more help than your family or other people could give?	☐	☐	☐	☐	
TREATMENT ISSUES:	**NOT AT ALL = 0, A LITTLE BIT = 1, QUITE A BIT = 2, VERY MUCH = 3**				
In the past month, have you been distressed or bothered by:	**0**	**1**	**2**	**3**	**Comments**
41. Side effects from your treatment?	☐	☐	☐	☐	
42. Worrying about long term effects from your treatment?	☐	☐	☐	☐	

PERSONAL ISSUES		
	Yes	**No**
43. Do you need any help with your personal affairs?	☐	☐
44. Would you like to talk to another professional about your condition or treatment?	☐	☐
45. Would you like any more information about the following?	**Yes**	**No**
a. Your condition	☐	☐
b. Your care	☐	☐
c. Your treatment	☐	☐
d. Other types of support	☐	☐
e. Financial issues	☐	☐
f. Other (please state):	☐	☐

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Are there any other concerns that you would like us to know about?
You can use this section to jot down any questions that you want to ask your doctors or other caring professionals …
Question 1
Question 2
Question 3

Centre - Vital Signs:					
BM	**BP:**	**Temp:**	**Rest Rate:**	**SATS:**	**GCS:**

PAIN SCALE:			
How intense is your pain now *(0 = no pain, 10 = extreme pain)*		How intense was your pain last week *(0 = no pain, 10 = extreme pain)*	
How distressing is your pain now *(0 = not at all, 10 = extremely)*		How distressing was your pain last wk *(0 = not at all, 10 = extremely)*	
How does the pain interfere with normal everyday activities *(0 = not at all, 10 = completely)*		If had treatment for pain, how much has this relieved the pain (0% = no relief, 100% = complete relief)	%