Triage Application Form for Palliative Radiation Therapy

Date (d/m/y) ___/___/_____ Application Type: □ Front office □ Telephone □ Mail

Patient Name: _____ Surname: _____ Gender: □ M □ F DOB (d/m/y): ____/____/_____

Telephone / Mail: _____

Patient comes from: □ Ward _____; □ D.H. _____ ; □ Home □ Home-Care □ Hospice _____;

□ Other _____ Referring Physician (if any) □ _____

Autonomous in Deambulation: □ Yes □ Wheelchair □ Bed ; Ambulance Arranged: □ Yes □ No

Radiation Therapy Medical Record already existent: NO □ YES □ N°_____

Primary Cancer Site:

□ Breast □ Lung □ Prostate □ Upper/ Lower GI: _____ □ Kidney □ Gyn

□ Head&Neck □ Multiple Myeloma □ Melanoma □ Other: _____

Application's Reason:

1. Spinal Compression: Neurological Symptoms? □ No □ Yes N° Days Duration of Symptoms _____
2. Mediastinal Syndrome: Symptoms? □ No □ Yes N° Days Duration of Symptoms _____
3. Bleeding: Hemoglobin_____ (Date ___/____/____) Transfusion? □ No □ Yes; Date last transfusion ____/____/___
4. Severe Bone Pain (NRS 8-10) not controlled by ongoing drug therapy
5. Mild to Moderate Bone Pain (NRS 1-7)
6. Other Non Bone Related Pain (NRS_____); Detail_____

Ongoing Pain Killers: _____

PMI (Pain Management Index) Value: _____; Suspect of Breakthrough Pain □

□ Painless Bone Metastases □ Adrenal Metastases □ Lymph-Node Metastases

□ Liver Metastases □ Brain Metastases □ Lung Metastases □ Other_____

NOTES: _____

Who Collected Info (Signature(ID): _____ Date (d/m/y) and time: _____
□ **Physician** □ **Nurse**

→ **Priority Assignment (MD):** □ Very High □ High □ Ordinary
→ **Outpatient Department (MD)**: □ Emergency □ Ordinary □ Multidisciplinary Pain Management □ Remote Visit

→ **Physician ID/Signature:** _____ **Date and Time Priorization:** _____ **Date Visit** d_____/m____/y___