



| <b>HEALTH CARE PERSONNEL FORM</b> |                                 |   |
|-----------------------------------|---------------------------------|---|
|                                   | <b>Patient's:</b>               | <b>Please fill in or tick the right box as appropriate</b>  |
| 18                                | Date of birth                   | (Day.Month.Year)  |
| 19                                | Principal diagnosis             | ICD-10 code:  |
| 20                                | Date of the principal diagnosis | (Month.Year)  |
| 21                                | Stage of the cancer disease     | <input type="checkbox"/> Local<br><input type="checkbox"/> Locally advanced<br><input type="checkbox"/> Metastatic/disseminated   |
| 22                                | Site of metastases              | <input type="checkbox"/> Bone<br><input type="checkbox"/> Liver<br><input type="checkbox"/> Lung<br><input type="checkbox"/> CNS<br><input type="checkbox"/> Other  |
| 23                                | Present anticancer treatment    | <input type="checkbox"/> Radiotherapy<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Hormone therapy<br><input type="checkbox"/> Other anticancer therapy<br><input type="checkbox"/> No anticancer therapy   |
| 24                                | Additional diagnoses            | ICD-10 code: _____, _____, _____, _____,<br>_____, _____, _____   |
| 25                                | Stage of the non-cancer disease | Chronic heart failure (CHF): The New York Heart Association (NYHA) Functional Classification; NYHA class: I <input type="checkbox"/> , II <input type="checkbox"/> , III <input type="checkbox"/> , IV <input type="checkbox"/><br>Chronic obstructive pulmonary disease (COPD): GOLD classification; stage: I <input type="checkbox"/> , II <input type="checkbox"/> , III <input type="checkbox"/> , IV <input type="checkbox"/><br>Dementia: FAST scale; stage: 1 <input type="checkbox"/> , 2 <input type="checkbox"/> , 3 <input type="checkbox"/> , 4 <input type="checkbox"/> , 5 <input type="checkbox"/> , 6 <input type="checkbox"/> , 7 <input type="checkbox"/> |
| 26                                | Medication                      | <input type="checkbox"/> Non-opioid analgesics<br><input type="checkbox"/> Opioids<br><input type="checkbox"/> Co-analgetics<br><input type="checkbox"/> Corticosteroids<br><input type="checkbox"/> Antidepressants<br><input type="checkbox"/> Antiemetics<br><input type="checkbox"/> Neuroleptics<br><input type="checkbox"/> Sedatives/anxiolytics<br><input type="checkbox"/> Drug(s) for acid related disorders<br><input type="checkbox"/> Laxatives  |



## BASIC DATASET

|    |                    |  |
|----|--------------------|--|
|    |                    | <input type="checkbox"/> Antibiotics<br><input type="checkbox"/> Diuretics<br><input type="checkbox"/> Heart medication / antihypertensives<br><input type="checkbox"/> Other  |
| 27 | Weight loss        | Involuntary weight loss ____ % and duration of weight loss ____ months   |
| 28 | Performance status | <input type="checkbox"/> 100 Normal; no complaints; no evidence of disease.<br><input type="checkbox"/> 90 Able to carry on normal activity; minor signs or symptoms.<br><input type="checkbox"/> 80 Normal activity with effort; some signs or symptoms of disease<br><input type="checkbox"/> 70 Cares for self; unable to carry on normal activity or to do active work.<br><input type="checkbox"/> 60 Requires occasional assistance but is able to care for most of his needs.<br><input type="checkbox"/> 50 Requires considerable assistance and frequent medical care.<br><input type="checkbox"/> 40 In bed more than 50% of the time.<br><input type="checkbox"/> 30 Almost completely bedfast.<br><input type="checkbox"/> 20 Totally bedfast and requiring extensive nursing care by professionals and/or family.<br><input type="checkbox"/> 10 Comatose or barely arousable.<br><input type="checkbox"/> 0 Dead |
| 29 | Cognitive function | The patient has cognitive impairment;<br><input type="checkbox"/> No<br><input type="checkbox"/> Mild<br><input type="checkbox"/> Moderate<br><input type="checkbox"/> Severe  |
| 30 | Place of care      | <input type="checkbox"/> Home<br><input type="checkbox"/> Long-term care facilities<br><input type="checkbox"/> Hospice / Palliative care unit<br><input type="checkbox"/> Hospital<br><input type="checkbox"/> Other  |
| 31 | Provision of care  | <input type="checkbox"/> Inpatient<br><input type="checkbox"/> Outpatient<br><input type="checkbox"/> Day care   |