Supplemental online content for:

Guiding Lay Navigation in Geriatric Patients With Cancer Using a Distress Assessment Tool

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eAppendix 2: High-Risk Categories

Cancer Types
- Leukemias, all types
- Esophageal
- Lung
- Head and neck
- Pancreatic
- Ovarian
- Brain
- Unknown primary

Comorbidities
- Congestive heart failure
- Diabetes
- Stroke/Transient ischemic attack
- Chronic obstructive pulmonary disease (COPD)
- Interstitial lung disease

Medications
- Aspirin and other antiplatelet agents
- Warfarin
- Digoxin
- Insulin/Hypoglycemic agents

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eAppendix 3: Common Interventions

- Provider referral/contact
- Educational and community resources
- Cancer education resources
- Cancer support group
- Exercise and physical activity tools
- Financial support
- Home health
- Hospice
- Insurance support
- Lodging/Discount lodging
- Meals/Meal vouchers
- Medical equipment
- Nutrition support
- Product coupons
- Social support
- Spiritual support
- Transportation support
eFigure 1. Modified distress assessment

PATIENT DISTRESS THERMOMETER

Date Administered: ____________________________  By: ____________________________
Patient Name: ____________________________  MR# ____________________________
DOB (00/00/0000): ____________________________  ___Formal___ Informal Assessment
Completed by: ___Patient, ___Child, ___Family Member, ___Friend, ___Spouse, ___Other

During the past week how distressed have you been? (Please shade in the thermometer to the right)

As part of our attempt to care for your total needs, we would like you to fill out the questionnaire on the following pages so that we may better approach your health care. We believe that all aspects of your life are important and have an effect on the way you feel.

___ Check if NO distress score was marked

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**eFigure 1. Modified distress assessment (cont.)**

Date Administered: __________________________  By: ______________________________
Patient Name: ____________________________  MR#__________________________

Do you wish to get help for any of the problems listed below?  Yes/No
If yes, which of these is/are most distressing?
If we cannot follow-up with you in clinic today, what is the best way to contact you?_____________
Check the causes of your distress (all that apply):

**PRACTICAL PROBLEMS:**
___Ability to use Phone  ___Child Care  ___Cooking
___Getting Groceries/Shopping ___Housekeeping ___Housing
___Insurance/Financial ___Manage Finances ___Transportation
___Work

**FAMILY PROBLEMS:**
Dealing with:  ___Children  ___Family Support
___Friends  ___Partner

**INFORMATION CONCERNS:**
Lack of Info About (my):
___Alternative Therapy Choices  ___Diagnosis/Disease  ___Diagnostic Results
___Diet/Nutrition  ___End of Life Issues  ___Hospice
___Home Health  ___Legal Issues
___Maintaining Fitness/Exercise  ___Performing Medical Procedures
___Prognosis  ___Scheduling  ___Survivorship
___Side-Effects/Treatment(s)  ___Side-Effects/Medication(s)
___Supportive Care  ___Treatment(s)  ___Treatment Decisions

**COGNITIVE PROBLEMS:**
___Feeling Confused  ___Forgetfulness  ___Poor Thinking
___Memory/Concentration  ___Seeing Things/Hearing Things
___Understanding Verbal or Written Words

**OTHER:**
___Ability to Read/Write  ___Cultural/Religious Needs
___Citizenship  ___Lack of Social Support
___Language Barrier  ___Post-op Care
# eFigure 1. Modified distress assessment (cont.)

<table>
<thead>
<tr>
<th>Physical Problems:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance/Walking &amp; Mobility Difficulty</td>
<td>Bathing/Dressing</td>
</tr>
<tr>
<td>Body Sores</td>
<td>Breathing</td>
</tr>
<tr>
<td>Changes in Urination</td>
<td>Constipation</td>
</tr>
<tr>
<td>Controlling Bowel Movement</td>
<td>Controlling Urination</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Dizziness</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Feeding Self</td>
</tr>
<tr>
<td>Getting Around-Inside Home</td>
<td>Getting Around-Outside Home</td>
</tr>
<tr>
<td>Hearing</td>
<td>Indigestion</td>
</tr>
<tr>
<td>Loss of Appetite</td>
<td>Mouth Sores</td>
</tr>
<tr>
<td>Nausea/Vomiting</td>
<td>Nose Dry/Congested</td>
</tr>
<tr>
<td>Opening Medication Bottles</td>
<td>Pain</td>
</tr>
<tr>
<td>Skin Dry/Itchy</td>
<td>Sleep/Insomnia</td>
</tr>
<tr>
<td>Swallowing</td>
<td>Swollen Arms/Legs</td>
</tr>
<tr>
<td>Tingling Hands/Feet</td>
<td>Toileting</td>
</tr>
<tr>
<td>Weight Change</td>
<td>Vision</td>
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</tbody>
</table>

<table>
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<tr>
<th>Emotional Problems:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjusting to Changes in Appearance</td>
<td>Adjusting to my Illness</td>
</tr>
<tr>
<td>Boredom</td>
<td>Concentration</td>
</tr>
<tr>
<td>Coping with Grief &amp; Loss</td>
<td>Emotional Control</td>
</tr>
<tr>
<td>Fear(s)</td>
<td>Feeling Depressed or “Blue”</td>
</tr>
<tr>
<td>Feeling Hopeless</td>
<td>Guilt</td>
</tr>
<tr>
<td>Intrusions (thoughts that appear suddenly and repeatedly that are not welcome)</td>
<td>Loss of Interest in Usual Activities</td>
</tr>
<tr>
<td>Isolation/Feeling Alone</td>
<td>Nervous/Anxiety</td>
</tr>
<tr>
<td>Managing Stress</td>
<td>Sadness</td>
</tr>
<tr>
<td>Role Changes (“Caring for Family”)</td>
<td>Worry</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spiritual/Religious Concerns:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Comfort, Strength or Hope from Spiritual Beliefs</td>
<td>Lack of Support from Spiritual/Religious Group</td>
</tr>
<tr>
<td>Facing my Mortality</td>
<td>Loss of Sense of Purpose</td>
</tr>
<tr>
<td>Loss of Faith</td>
<td>Trust in God</td>
</tr>
<tr>
<td>Meaning of Life</td>
<td>Relating to God</td>
</tr>
</tbody>
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