

PSA Care Plan for patient to complete and bring to their welcome appointment



Prostate Cancer Care Plan (please bring this to your next prostate cancer appointment)

We have asked you to complete a Prostate Cancer Care Plan. This provides us with information to give you the best support to manage your condition. This document lists some issues / concerns. Please indicate if any apply to you and if so which you would like to discuss at your next prostate cancer review with your GP/Practice Nurse.

Physical Concerns	Yes	No	Discuss	Practical Concerns	Yes	No	Discuss	Relationship Concerns	Yes	No	Discuss
Problems when urinating or loss of bladder control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caring for others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Bowel control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Housing or finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation or diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parking or transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	With others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding from the bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work or education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spiritual /religious Concerns	Yes	No	Discuss
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grocery shopping or making food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of faith or other spiritual concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bathing or dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Bone pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laundry or housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Information needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Poor sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional Concerns							
Problems getting or keeping an erection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loneliness or isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
No or loss of sex drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sadness or depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Unplanned weight gain or feeling swollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worry, fear or anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Unplanned weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Helplessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Please write down anything else you wish to discuss with the GP or Practice Nurse:

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Prostate Holistic Care Plan for **(Patient's name.)**

With thanks to STAR Project Team Southampton University Hospital and the Transforming Cancer Services Team for London for allowing us to adapt their assessment tool.