

UROLOGY PRIORITY CRITERIA TOOL

May 2008

Patient Name: _____	HSN: _____
Patient Date of Birth _____ MM DD YYYY	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
This Form Completed By:	
Surgeon _____	
Other Clinician _____	
Office Staff _____	
Does your patient want a confirmation letter? If NO check here <input type="checkbox"/>	

Please check the box that most accurately describes the patient's current situation.

<p>1) Score as proven or suspected cancer only if the patient is being treated for a malignancy or if clinical features and investigations include malignancy in differential diagnosis. Please check the box that most accurately describes the patient's current situation (do not include TURPS, please refer to Cancer Guide for explanation):</p> <p><input type="checkbox"/> Patient with proven or suspected invasive cancer. Priority 1 - 95% of surgeries to be performed within 3 weeks.</p> <p><input type="checkbox"/> Patient with proven or suspected indolent cancer. Priority 3 - 90% of surgeries to be performed within 3 months.</p> <p><input type="checkbox"/> Patient requires a routine screening or follow-up procedure for cancer detection. A scheduled procedure to be performed within 12 months.</p>																																				
<p>2) Is the patient catheterized and requiring a TURP or bladder stone removal? (automatically Priority Level I)</p> <p><input type="checkbox"/> Yes (do not answer questions 3 to 10)</p>	<p>3) Usual frequency of painful episodes/suffering:</p> <p>0 <input type="checkbox"/> None 6 <input type="checkbox"/> Often 3 <input type="checkbox"/> Occasional 9 <input type="checkbox"/> Constant</p>																																			
<p>4) How intense is the pain at its worst?</p> <p>0 <input type="checkbox"/> None 3 <input type="checkbox"/> Moderate 1 <input type="checkbox"/> Mild 4 <input type="checkbox"/> Severe</p>	<p>5) Potential for organ damage if not treated surgically?</p> <p>0 <input type="checkbox"/> None 12 <input type="checkbox"/> Moderate 8 <input type="checkbox"/> Mild 16 <input type="checkbox"/> Severe</p>																																			
<p>6) Usual intensity of other forms of suffering. Please specify form of suffering (check all that apply):</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 12.5%;">None</th> <th style="width: 12.5%;">Mild</th> <th style="width: 12.5%;">Moderate</th> <th style="width: 12.5%;">Severe</th> </tr> </thead> <tbody> <tr> <td>Hematuria</td> <td>0 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>6 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> </tr> <tr> <td>Fatigue/Constitutional symptoms</td> <td>0 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>6 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> </tr> <tr> <td>Weight loss</td> <td>0 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>6 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> </tr> <tr> <td>Psychological stress such as anxiety or depression</td> <td>0 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> <td>12 <input type="checkbox"/></td> </tr> <tr> <td>Nocturia</td> <td>0 <input type="checkbox"/></td> <td>2 <input type="checkbox"/></td> <td>6 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> </tr> <tr> <td>Incontinence</td> <td>0 <input type="checkbox"/></td> <td>4 <input type="checkbox"/></td> <td>8 <input type="checkbox"/></td> <td>12 <input type="checkbox"/></td> </tr> </tbody> </table>			None	Mild	Moderate	Severe	Hematuria	0 <input type="checkbox"/>	2 <input type="checkbox"/>	6 <input type="checkbox"/>	8 <input type="checkbox"/>	Fatigue/Constitutional symptoms	0 <input type="checkbox"/>	2 <input type="checkbox"/>	6 <input type="checkbox"/>	8 <input type="checkbox"/>	Weight loss	0 <input type="checkbox"/>	2 <input type="checkbox"/>	6 <input type="checkbox"/>	8 <input type="checkbox"/>	Psychological stress such as anxiety or depression	0 <input type="checkbox"/>	4 <input type="checkbox"/>	8 <input type="checkbox"/>	12 <input type="checkbox"/>	Nocturia	0 <input type="checkbox"/>	2 <input type="checkbox"/>	6 <input type="checkbox"/>	8 <input type="checkbox"/>	Incontinence	0 <input type="checkbox"/>	4 <input type="checkbox"/>	8 <input type="checkbox"/>	12 <input type="checkbox"/>
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<p>7) Degree of impairment in usual activities due to surgical condition:</p> <p>0 <input type="checkbox"/> Not impaired at all/mildly impaired 5 <input type="checkbox"/> Able but difficult and/or somewhat impaired 10 <input type="checkbox"/> Able but very difficult and at much reduced level 15 <input type="checkbox"/> Totally dependent (unable to perform any usual activities)</p>																																				
<p>8) Recent history of major complications of condition OR significant physical exam results OR significant test results:</p> <p>0 <input type="checkbox"/> No 8 <input type="checkbox"/> Yes</p>																																				
<p>9) Life-expectancy implications of condition without procedure:</p> <p>0 <input type="checkbox"/> Minimal threat to life 10 <input type="checkbox"/> Patient faces somewhat reduced life expectancy 15 <input type="checkbox"/> Patient faces substantially reduced life expectancy 20 <input type="checkbox"/> Patient has condition that is likely to be fatal between six months and two years 25 <input type="checkbox"/> Patient has condition that is likely to be fatal within six months</p>																																				
<p>10) Expected improvement in life expectancy with surgery:</p> <p>0 <input type="checkbox"/> None 10 <input type="checkbox"/> Moderate 5 <input type="checkbox"/> Minimal 20 <input type="checkbox"/> Major</p>																																				