THORACIC SURGERY PRIORITY CRITERIA TOOL

September 2007

Patient Name: _____ HSN:_____

Patient Date of Birth ____ _____ _____ (MM DD YYYY) Sex: ☐ M ☐ F

This Form Completed By:
Surgeon _____
Other Clinician _____
Office Staff _____

Does your patient want a confirmation letter? If NO check here ☐

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

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:

☐ Patient with proven or suspected invasive cancer.
Priority 1 - 95% of surgeries to be performed within 3 weeks.

☐ Patient with proven or suspected indolent cancer.
Priority 3 - 90% of surgeries to be performed within 3 months.

☐ Patient requires a routine screening or follow-up procedure for cancer detection.
A scheduled procedure to be performed within 12 months.

2) Usual **frequency** of painful episodes/suffering:

0 ☐ None
1 ☐ Occasional
3 ☐ Often
4 ☐ Constant

3) How **intense** is the pain at its worst?

0 ☐ None
3 ☐ Mild
6 ☐ Moderate
9 ☐ Severe

4) Usual **intensity** of other forms of suffering. Please specify form of suffering (check all that apply):

	None	Mild	Moderate	Severe
Nausea or vomiting	0☐	4☐	8☐	12☐
Fatigue	0☐	4☐	8☐	12☐
Weight loss	0☐	4☐	8☐	12☐
Economic factors	0☐	4☐	8☐	12☐
Dyspnea	0☐	4☐	8☐	12☐
Psychological stress such as anxiety or depression	0☐	4☐	8☐	12☐
Sepsis	0☐	4☐	8☐	12☐

5) Degree of impairment in usual activities due to surgical condition:

0 ☐ Not impaired at all/mildly impaired
5 ☐ Able but difficult and/or somewhat impaired
10 ☐ Unable to pursue educational/occupational/recreational activities

6) Recent history of major complications of condition ***OR*** significant physical exam results ***OR*** significant test results:

0 ☐ No 15 ☐ Yes

7) Expected improvement in life quality with surgery:

0 ☐ None 10 ☐ Moderate
5 ☐ Minimal 20 ☐ Major

8) All things considered, how would you rate the urgency or relative priority of this patient? (Draw a line.)

0 1 2 3 4 5 6 7 8 9 10
Not urgent at all — Extremely Urgent (just short of an emergency)

9) In your clinical judgment, what should be the maximum acceptable waiting time for this patient?

Number of days: _____ **or** weeks: _____ **or** months: _____