Hospital at Home (HaH) Caregivers: Oncology Tip Sheet

Today is Day ________ after Chemotherapy

Do you have any new symptoms or concerns since you were last seen?

Do you have:

**Fevers/Chills?**
- Are you taking your temperature at least twice daily?
- Are you keeping a record?

**Nausea and/or vomiting?**
- If Yes, how many times in the past 24 hours?
- Are you able to eat/drink?
  - If yes, how much fluid have you had in last 24 hours (2L/day goal)
- Are you eating 3 meals/day?
- Are you able to take your meds?
- Are you taking anti-nausea meds? And does is help?

**Diarrhea?**
- If Yes, how many episodes in last 24 hours?
- Is it watery or is there consistency to it?
- Is it large volume?
- Are you taking anti-diarrhea meds? And does is help?

**Dizziness?**

New or ongoing **Pain?**

**Shortness of Breath?**

**Chest Pain?**

**Headache?**

What is your activity level?
Do you get out of bed and walk around your home?