

Oncology Rehabilitation Goal Setting and Functional Assessment



UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: ____ / ____ / ____ Sex: M / F

Affix Hospital ID Label If Available

Initial assessment date:

Diagnosis:	Current Treatment: <input type="checkbox"/> None <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy <input type="checkbox"/> Hormone <input type="checkbox"/> Other Details: Past Treatment: <input type="checkbox"/> None <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Radiotherapy <input type="checkbox"/> Hormone <input type="checkbox"/> Other Details:
Past History:	Exercise Considerations/ Side Effects: Fatigue: CAPO rating (please circle) No Fatigue Mild Moderate Severe
Social History:	Falls (Past 12 months):
Premorbid Mobility & Exercise:	Current Mobility & Exercise:

Physical Measures			
Height (cm)	Weight (kg)	BMI	SpO2
Resting BP	Resting HR	Est. Max HR	

Signature: _____	Name (please print): _____	Designation: _____	Date: _____
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Oncology Rehabilitation Exercise Assessment



UR Number: _____
 Surname: _____
 Given Name: _____
 Date of Birth: ____/____/____ Sex: M / F

Affix Hospital ID Label If Available

Pre Assessment Date _____			
6 Minute Walk Test			
Total Distance		SpO2	HR
	1		
BORG Pre: Post:	2		
Gait Aid:	3		
No. of rests:	4		
Distance before 1 st rest	5		
	6		
	rest		
Sit to Stand x5 (46cm chair height)			
Time:		Hands used:	
Step Test – 15secs (support leg)		CTSIB	
Left	Right		
Biceps Curl 10RM			
Left	Right		
Other			
ROM:			

Post Assessment Date _____			
6 Minute Walk Test			
Total Distance		SpO ₂	HR
	1		
BORG Pre: Post:	2		
Gait Aid:	3		
No. of rests:	4		
Distance before 1 st rest	5		
	6		
	rest		
Sit to Stand x5 (46cm chair height)			
Time:		Hands used	
Step Test (15 sec)		CTSIB	
Left	Right (support leg)		
Biceps Curl 10RM			
Left	Right		
Other			
ROM:			

Signature: _____ Name (please print): _____ Designation: _____ Date: _____