[ARIA: DATE]

Shared Care Information Exchange

We are sharing the care of this advanced colorectal cancer patient. To foster collaborative care, we would like to provide you the opportunity to ask any questions and individualize this patient's care plan.

Please confirm your clinic is this patient's current medical home:

☐ Yes ☐ No (if No, no further comments are required)

☐ Please confirm you are managing **non-cancer** related concerns and medication refills:
Comments: ____

____

____

Do you have alternate clinic contact information the medical oncologist should use to contact you?

Do you feel comfortable in participating in the palliative approach to care for this patient?

Approach to Care	Yes	No	Comments
Symptom Management: (E.g. opioids if required)			
Psychosocial: (E.g. family distress)- are SW access and other supports available?			
Advance Care Planning- do you have a Goals of Care Form (Green Sleeve) on file? (please fax copy if so)			

Non urgent questions you would like answered: ____

____

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Please fax this cover letter back to: 403-283-1651.

For non-urgent messages please contact the medical oncologist via the contact information in the attached letter.

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Re: Advanced Cancer Shared Care

Dear Dr. ___________,

Your patient [Aria: Insert name] is in treatment at our Cancer Centre for an advanced, incurable, colorectal cancer. This requires a **collaborative effort and a palliative approach to care**. We will work closely with you to coordinate care, improve quality of life and symptom management. We appreciate your ongoing management of non-cancer related problems, while the Cancer Centre will focus on issues related to cancer and its treatment. This document outlines **relevant information for you as their primary care provider related to:**

- Potential signs and symptoms of cancer related emergencies
- Other palliative supportive measures
- Contact information for the GI oncology team

Please refer to the latest consultation note for prognosis specific to your patient (will be sent separately). If no prognosis is noted or you have further questions, please contact us. All Cancer Centre consult and progress notes, imaging, and lab work are available in NetCare. At any time if you have any concerns or are in need of more information, please contact the medical oncologist.

COLLABORATIVE CARE

We have asked the patient to make a follow up appointment with you and your team. Maintaining a close relationship is important for emotional support, advance care planning and follow-up of non-cancer related health issues. Studies suggest that active involvement with family physicians, psychological and emotional services, and connections within the community improve patient and family outcomes. We ask that non-cancer related concerns and issues including medications be managed by your team. Symptoms can also be co-managed together. To optimize shared care, please communicate to us any significant changes or updates.

Care Component	Cancer Care Team	Family Medicine Team
Chemotherapy and chemotherapy related concerns	•	
Organizing investigations related to cancer treatment	•	
Symptoms (i.e. pain, anxiety, depression, sleep disturbances, constipation, psychosocial)	•	•
Advance Care Planning	•	•
Patient and Family concerns	•	•
Legal/financial concerns (e.g. POA)	•	•
Accessing community resources	•	•
Non-cancer comorbidities		•

Please note patients with pre-existing:

- **Diabetes** may require changes to their medications due to changes in oral intake, weight loss, and concurrent antiemetic medications.
- **Anti-hypertensives** may require adjustments, especially if they lose weight.

It is advised to avoid becoming pregnant or fathering a child while receiving chemotherapy. An adequate method of contraception should be used for both men and women. The combination of a barrier method and the contraceptive pill would give the best protection.

MONITORING FOR COMPLICATIONS

Chemotherapy side effects will have been reviewed in previous letters prior to initiation of treatment.

- **Fever** (temperature over **38°C for one hour or 38.3°C once**) **while on chemotherapy**, may indicate life threatening febrile neutropenia. Direct patient to Emergency Room.

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Common Treatment- Related Complications/Symptoms:

Complication	Treatment-Related Causes	Notes
Fatigue	• Radiation • Chemotherapy	Fatigue related to treatment may improve post treatment, or may progress with disease progression. Patient educational resources are available at cancer centers and online.
Peripheral neuropathy	• Oxaliplatin chemotherapy	Peripheral neuropathy should improve over months once chemo is completed. Consider referral to OT/PT if affecting ADLs.
Chronic GI symptoms	• Radiation • Chemotherapy	Symptoms such as chronic diarrhea, constipation and pain should be treated as appropriate.
Psychosocial distress	• Stress of cancer treatment • Fear of disease progression • Post-treatment adjustments	Consider Local resources (Local Access Mental Health, Primary Care Network, and patient support groups). Psychosocial oncology is available for counselling of **oncology related distress** even if patient is no longer in treatment.
Sexual dysfunction	• Radiation • Chemotherapy • Surgery	Some patients may experience decreased libido, loss of intimacy with their partners or pain with sexual activities. Further assessment should be done to rule out depression. Referral to psychosocial oncology may be helpful.
Hand and Foot Syndrome	• Capecitabine (Xeloda) chemotherapy	Some patients may have numbness, tingling, mild erythema and swelling of hands or feet. Pain, moist desquamation, ulceration or blisters requires notification of the oncology team. Remind patient to keep soles and palms well moisturized with mild creams.
Venous Thromboembolic Disease	• Higher risk due to cancer	Patients will have lifelong elevated risk for pulmonary embolus and deep vein thrombosis.

For further information on managing cancer and treatment related symptoms, please discuss with the oncologist or for symptom management tip sheets visit www.ahs.ca/GURU and go to "Palliative & Supportive Care".

ONCOLOGICAL EMERGENCIES

A full description of oncological emergencies can be found in "**Oncologic Emergencies: a Guide for Family Physicians**", available through AHS's Primary Health Care Resource Centre: https://www.ahs.ca/info/Page14872.aspx

Colorectal cancer increases risk for:

- Malignancy associated **hypercalcemia.**
  - Signs may include nausea, somnolence, confusion, weakness, constipation
- Malignant spinal **cord compression**.
  - Signs may include new onset limb weakness, loss of sensation in feet or legs, bowel/bladder retention (or incontinence), back pain, especially radiating like a band. Requires emergent referral to **Radiation Oncology.** The patient should be sent to **Emergency** for assessment. Palliative specialist teams (if already involved) may be able to expedite urgent assessment on their inpatient units.

Please alert the medical oncologist, or if after hours the medical oncologist on call through switchboard of your cancer centre, as they may be able to expedite assessment.

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REFERRALS AND CLINICIAN ADVICE

A palliative approach to care requires more than just managing symptoms. We recommend starting referrals early to ensure a strong community support system is in place to prevent crisis situations.

For more information on how to refer and additional services:

- **Alberta Referral Directory (ARD)**: for referral process, eligibility requirements, estimated wait times, required information/tests and forms. https://albertareferraldirectory.ca
- The referrals section of NetCare
- View additional service descriptions at www.specialistlink.ca or at www.ahs.ca/GURU under "Palliative & Supportive Care"

Service	Description	Referrals and Information
Radiation Oncology/Medical Oncology		Routine Referral for Radiation Oncology: • TBCC Appointment line 403-521-3722 OR Fax referral forms to 403-521-3245 **Clinician Advice**: After hours: Main switchboard of hospital and ask for Medical or Radiation Oncologist on call For emergencies and if your region does not have a cancer center: • RAAPID North (for patients north of Red Deer, Alberta) Phone:1-800-282-9911 or 780-735-0811 • RAAPID South (for patients in and south of Red Deer, Alberta) Phone: 1-800-661-1700 or 403-944-4486
Integrated Home Care	In-home care and support (example: nursing services, personal care, respite services, wound care, case coordination, home care aides, equipment).	Calgary Community Care Access Phone: 403-943-1920 or 1-888-943-1920 Fax: 403-943-1602
Palliative Home Care	In-home care and support. Focus on managing symptom issues, providing emotional and psychological support for clients with a progressive, life limiting illness. On call 24/7 support. Available only in Edmonton and Calgary cities. **Rest of province: No specialized palliative home care program, instead Integrated Home Care with Palliative Care Consult support.**	Calgary Community Care Access Phone: 403-943-1920 or 1-888-943-1920 Fax: 403-943-1602
Palliative Care Consultants (urban, rural, long term care, acute care)	Provides palliative care consultative support for adult clients, families, and healthcare teams to help manage complex palliative symptoms related to the client's life-threatening disease. Consultants work with current providers in a consultative role to better support the patient /family and attending teams. **Consultants do not assume the role of most responsible physician.** **Rural**: If home visit is requested, the client should be admitted to **Integrated Home Care**. A joint home visit will be ideally arranged with the Case Manager.	Routine Referral: • Alberta Referral Directory Clinician Advice: • Urgent Advice (<1hr): Specialist Link Phone: 403-910-2551 • RAAPID North (for patients north of Red Deer, Alberta) Phone 1-800-282-9911 or 780-735-081 • RAAPID South Phone: 1-800-661-1700 or 403-944-4486 • Non-urgent advice (<5 days): Netcare eReferral (eAdvice)

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Complex Cancer Management Service (Pain/Palliative Tumor Group) at the Tom Baker Cancer Centre	Consultative service (Physician/NP) for patients with complex **cancer-related** pain and symptom issues. Consultants facilitate ongoing symptom management and palliative care by patients' primary health care teams, via in-centre consult and collaboration with community and acute care providers/resources. Patients must have symptoms caused by cancer or cancer treatment. **Consultants do not assume the role of most responsible physician.** **This service is available to current TBCC patients.**	Routine Referral: • Fax referral to TBCC Central Access & Triage: Fax: 403-521-3245 • Triage Coordinator: Phone: 403-521-3589 Clinician Advice: • On Call Service (AHS pager #10691 - weekdays)
EMS-ATR	The EMS PEOLC ATR (Assess, Treat and Refer) program is for any adult patient receiving palliative or end of life care in the community setting (private home, supportive living site, long term care facility, and/or hospice) that may benefit from EMS involvement for urgent symptom management. Clinician (MD or homecare RN) should be present/available by phone to coordinate care with EMS. **The patient must be recognized as palliative or end-of-life and would benefit from EMS involvement for urgent symptom management**.	Registered clinician through 911 dispatch using the **clinician dispatch script** (find script searching internet for EMS-ATR and click on “Health Professionals”)
Community Paramedic Program	Non-emergent program for patients with chronic health concerns that prevent them from accessing available health care services. A range of medical services provided in the home. Preference of clinician present/available by phone to coordinate care. This program does not transport patients to acute care facilities. Operates 7 days a week from 0600 to 2200 hours with no cost to the patient.	Routine Referral: • Patients South of Red Deer Phone: 1-855-491-5868 Fax:403-776-3835 • Patients in and North of Red Deer Phone: 1-833-367-2788 Fax:780-735-0421
Alberta Cancer Line	A provincial central contact service that can assist nurses, physicians, or other health care professionals with information on referrals, closer to home treatment programs, contact oncologists or other specialist oncology professionals (educators, pharmacists, psychosocial), and/or assist with accessing support services within AHS Cancer Care.	Available Monday to Friday 8-4pm Phone: 1-888-432-8865

SURVEILLANCE

We would recommend **cessation of screening for other cancers** in the setting of advanced incurable colorectal cancer. Screening may be considered in a very small subgroup of patients where advanced disease is relatively indolent or its treatment is expected to result in prolonged survival.

ADVANCE CARE PLANNING (ACP)

- It is important to discuss **advance care planning** (e.g. selecting an alternate decision maker and creating a personal directive) and personal and treatment goals, e.g. determining a Goals of Care Designation (GCD), with the patient throughout the disease course. All teams involved in the patient’s care have this responsibility.
- Please review your patient’s Green Sleeve to see their current GCD. Order a new GCD if there is no preexisting order, or if the existing GCD no longer **reflects the patient’s values** and their medical context.
- **Document your conversations** on the ACP GCD Tracking Record, so that the patient’s values and plans will be available to other clinicians providing care to this patient. Ensure the Tracking Record is returned to the patient’s Green Sleeve.
- Remind the patient to keep the Green Sleeve on or near the fridge at home and to take it with them to clinic or hospital visits.

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For more information and to obtain Goals of Care Designation and Tracking Record documents please refer to *www.conversationsmatter.ca*

PATIENT SUPPORT AND GENERAL RECOMMENDATIONS

Modifiable lifestyle factor	Recommendations
Smoking	Practice smoking cessation. For help contact Alberta Quits 1-877-710-QUIT (7848) or *www.albertaquits.ca* and visit *www.ahs.ca/guru* for clinical practice guideline.
Sun exposure	Chemotherapy and radiation treatment can cause skin sensitivity. Advocate for the use of sunscreen (minimum 15 SPF) and sunglasses. Advise against the use of indoor tanning beds.
Immunizations	Annual non-live influenza vaccination, unless contraindicated. Other vaccinations as appropriate (i.e. pneumococcal).

Other Available Resources:

Local Tips for providers: at *www.specialistlink.ca* or at *www.ahs.ca/GURU* under “Palliative & Supportive Care”

Inform Alberta- *www.InformAlberta.ca* to search resources in your community
A patient orientated booklet “**Sources of Help**” can be found on the internet by searching “Sources of Help AHS”. The booklet contains more information and links to:

- Cancer support groups
- Cancer and Work
- Counselling and support
- Symptom Management
- Palliative Care
- Grief support
-

Ostomy support: All patients can **self-refer to their local Enterostomal Clinic.** Patients should call their local hospital switchboard operator and ask to be connected. Please note that an Enterostomal nurse (ET nurse) is the only person to **authorize coverage for supplies** (physicians cannot).

Should you need to update your fax number, please call 403-521-3723. We appreciate your partnership in caring for this patient.

Sincerely,

[Aria: MO Sig Block]

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