UK SACT BOARD

Standardising reviews of adult patients receiving SACT for solid tumours

Version 1.0
27th November 2025

Contents

1. Foreword and Executive Summary

1.1 This guidance has been produced by the UK SACT Board (UKSB) and is intended for use in all UK oncology departments. It was commissioned by NHS England but clinical experts from all devolved nations have contributed. Clinical teams should review local policies and governance arrangements to incorporate this guidance where appropriate.

1.2 The UKSB strongly recommends moving away from the traditional model of review by a doctor before each cycle of treatment as this is often unnecessary with modern treatments that are usually well-tolerated. We recommend considering the prescribing and reviewing roles separately and suggest a governance framework for both. We suggest a system of review tiers to help departments consider which patients may not need a review before every cycle of SACT.

2. Background

2.1 Systemic anti-cancer therapy (SACT) delivery in the UK is increasing by about 6% annually. Patients with cancer are living longer and having more sequential lines of treatment. The increasing demand for SACT is outstripping capacity (medical, nursing, pharmacy, physical space in hospitals) and leading to delays in treatment.

2.2 SACT now encompasses a large range of treatments that vary in their method of administration (eg. oral, subcutaneous, intravenous). Many new treatment regimens that are being approved and funded include maintenance treatments in the adjuvant or disease-control settings where treatment can continue for many months or years. Patients receiving these therapies are often more clinically stable than those having palliative SACT and may have fewer decision-points (eg. response assessments).

2.3 SACT is usually prescribed many days or even weeks in advance of treatment being delivered. An extra step to confirm that the patient is well enough for SACT, that blood parameters have been met, other critical tests reviewed and that SACT can be safely dispensed and administered according to local protocols is therefore incorporated in most departments.

2.4 There is variation between departments in how and by whom patients are reviewed or assessed, the tools used to carry out assessments, and the frequency of assessments. Reviews may be based on clinical trial protocols where the frequency and complexity of assessments are more rigorous than is required in routine clinical practice.

2.5 SACT pharmacy verification is undertaken by a suitably trained registered pharmacy professional (RPP) to ensure the safe use of SACT through identification, resolution and prevention of medicine-related problems. Verification ensures the SACT and all other medicines are prescribed legally and are clinically appropriate for the patient.

3. Scope and rationale

3.1 This guidance aims to reduce unnecessary variation in practice between centres in how patients on SACT are reviewed. It aims to give teams and departments confidence to streamline their reviews and move away from the traditional medical review model towards more tailored reviews depending on the regimen, risk of toxicity and the individual patient while ensuring appropriate governance processes are followed to ensure patient safety.

3.2 It is intended for use in adult patients (>18 years) with solid tumours having SACT by any route (intravenous, oral etc.). We hope to include SACT for patients with haematological malignancies in a future version of the guidance.

3.3 Patients having SACT as part of clinical trials should be reviewed and assessed prior to each cycle according to the clinical trial protocol.

4. SACT prescribing and review roles and their governance

4.1 Prescribing and the role of the SACT prescriber

4.1.1 In many departments, SACT is prescribed in advance of the patient being assessed and reviewed to streamline SACT preparation (compounding and/or dispensing). A *SACT prescriber* can be a doctor or a non-medical prescriber (NMP). The UK SACT Board has published recommendations for recording and assessing competencies for SACT prescribing.

4.1.2 Doctors and NMPs who prescribe SACT should be working within an agreed scope of practice (see UKSB guidance on competencies for reviewing and prescribing SACT).

4.1.3 NMPs usually work in site-specific teams to support patients with one or more cancer types. The UK SACT Board strongly supports these roles and this

guidance is intended to promote their development within cancer teams and not to restrict the groups of patients they review.

4.1.4 When prescribing SACT in advance, the prescriber should consider all relevant information to decide if the SACT dose or frequency needs to be modified. This might include information about previous toxicities, tumour marker blood results, acute oncology service calls, emergency admissions or any other information which would affect fitness for treatment.

4.1.5 A SACT prescriber does not need to assess every patient at each cycle. The frequency for a prescriber assessment will depend on the expected toxicity of the regimen, toxicity of previous doses and individual characteristics of the patient (eg. comorbidities, performance status, frailty).

4.1.6 A SACT prescriber may prescribe several cycles at a time, noting the need for a Fitness for Treatment Review before each cycle is administered.

4.1.7 When prescribing SACT, the prescriber should check that appropriate imaging response assessments and any other monitoring tests (eg echocardiograms) have been requested and that clinic appointments to discuss these have been arranged.

4.1.8 A prescription may need to be changed following a Fitness for Treatment Review (see below). Departments should put systems in place so that a prescriber is available to make such changes at short notice, for example by ensuring cross-cover within tumour site teams.

4.1.9 In England the criteria for prescribing drugs approved by the Cancer Drugs Fund usually include a statement about when the first medical review of efficacy and toxicity should occur. These requirements, and any devolved nations equivalents, should be adhered to when considering this guidance.

4.1.10 Extra outpatient appointments may be required during a course of SACT to discuss other aspects of cancer care such as genetic testing, symptom control or new imaging results. A more streamlined, multi-professional approach to SACT reviews should create more space in medical clinics for these appointments.

4.2 The Fitness for Treatment Review and the role of SACT reviewers

4.2.1 A formal review to confirm that a patient is fit for a SACT cycle to be administered can be carried out by a prescriber or by a registered healthcare professional with appropriate training and competency assessment (eg. a doctor, SACT nurse, pharmacist or pharmacy technician). These groups are referred to as *'SACT reviewers*' in this guidance.

4.2.2 Departments should have a policy for SACT reviewers which should include a description of the competencies and training required to undertake reviews.

4.2.3 A SACT reviewer should work to a clear scope of practice defined within their clinical governing organisation policy. This should include

- The training / competency requirements
- Definitions of the parameters of practice (this may include specific treatment areas or tumour group(s) and frequency of SACT prescriber reviews)
- Clear mechanisms for escalation or referral back to SACT prescribers where the parameters of protocol are not met
- A robust process for auditing practice.

4.2.4 SACT reviewers should have an annual assessment of competency.

4.2.5 A review may be by telephone, videocall or face-to-face. It will usually be carried out one or two days before treatment to allow time for prescriptions to be modified if required.

4.2.6 A review should include an assessment of all pre-treatment parameters defined within the specific SACT protocol and any other factors which may change the appropriateness of the SACT which has been prescribed including:

- Blood test results
- Other critical tests eg cardiac assessment (ECHO, MUGA, ECG), pulmonary assessment (PFTs) etc.
- Treatment toxicity assessment using validated tools such as the UKONS triage tool, common toxicity criteria (CTCAE)
- Performance status and frailty using recognised grading systems
- Assessment of hypersensitivity reactions at any previous cycle
- Any other relevant information such as recent clinic letters, AOS visits, hospital admissions, GP attendance, new medications prescribed or purchased
- Information on response to treatment such as radiology reports or tumour markers

- Assessment of physical or psychosocial aspects which might affect the appropriateness of treatment such as ability to swallow oral medication, medication concordance or patency of PICC lines.
- Any other concerns raised by the patient about side effects or tolerability.

4.2.7 A review should use standardised review tools and checklists where possible. These include Common Toxicity Criteria for Adverse Events (CTCAE) scores, performance status, frailty score etc.. See appendix for an example. Consider using validated eProms to collect toxicity information where possible where local governance processes support this.

4.2.8 A SACT reviewer should work within clear protocols for escalation in the case of toxicities, blood results or other critical test parameters which are outside the expected range specified as specified in the SACT protocol.

4.2.9 The reviewer should check that the prescribed SACT doses and supporting medications are correct in the light of the above. If changes need to be made to SACT doses or supporting medications, these should be escalated to a SACT prescriber. Any grade 3 or 4 toxicity since the previous SACT dose should be discussed with a prescriber as it will usually necessitate a change in dose or a delay to treatment.

4.2.10 Documentation of the Fitness for Treatment Review should be recorded in the patient's clinical record.

4.2.11 Any acute admission to hospital since the previous SACT cycle should be discussed with the relevant medical team. This is particularly important in patients having SACT for advanced, incurable cancer as an acute admission is a predictor of mortality and should provoke discussions about future care planning in a 'What matters to you' conversation.

4.2.12 Recommendations contained in the Summary of Product Characteristics for the administration of drugs can be stringent. It may be appropriate to relax these in accordance with a SACT protocol which has been assessed and approved through appropriate local governance processes (eg. for sc trastuzumab).

4.2.13 Patients should be given clear information on how they will be reviewed while having SACT as part of the informed consent discussion. This should include who will be reviewing them and why and the way they can access support in between assessments. This is particularly important when moving from one SACT regimen to another.

4.3 SACT nurse review on the day of treatment

4.3.1 The Fitness for Treatment Review may occur on or before the day of treatment. Prior to SACT administration on the day of treatment, the nurse administering treatment should check that the patient's condition has not changed since the Fitness for Treatment Review and that any new blood tests have been reviewed according to the SACT protocol criteria. Any concerns should be escalated to a trained SACT reviewer or prescriber as appropriate.

5. The SACT protocol

5.1 Each department must have a protocol for each SACT regimen agreed through local, regional or national governance routes. The UKSB strongly advocates for protocols to be developed at a Cancer Alliance or national level to reduce duplication and improve standardisation and quality.

5.2 Departments should have on-line SACT protocols easily available to all staff involved in the delivery of SACT. These should be based on the UK SACT Board Guidance on the Contents of a SACT Protocol.

5.3 A protocol should specify the minimum frequency of investigations, medical clinic appointments, Fitness for Treatment Reviews and prescriber assessments for each regimen. This may be most clearly demonstrated in a table (see Table 1 below).

5.4 A protocol should specify the parameters which must be considered before SACT can be administered and the escalation protocol if those parameters are not met (eg. dose reduction, when a prescriber assessment is needed). This should include the duration of validity of blood tests.

Table 1. Example table to demonstrate minimum frequency of investigations, Fitness for Treatment Reviews and prescriber assessments

	Pre	Cycle1 day1	Cycle 1 day 8	Cycle 2 day 1	Cycle 2 day 8	Cycle 3 day 1	Cycle 3 day 8	Cycle 4 day 1	Notes
FBC	X	X	X	X	X	X	X	X	
U&E and LFTs	X	X		X		X		X	
Fitness for Treatment Review	X	X	X	X		X		X	
Prescriber assessment	X							X	Usually every 3 cycles
Imaging	X							X	Usually every 3 cycles
Clinic review	X							X	

6. Review assessment frequency and the concept of review tiers

6.1 The frequency of reviews and prescriber assessments will depend on the expected toxicity of the regimen, treatment intent, the toxicity experienced by the patient with previous doses, patient characteristics such as performance status and frailty and how long the patient has been having that SACT regimen.

6.2 The UK SACT Board suggests using a system of review tiers (see table below) to clarify the minimum frequency for Fitness for Treatment reviews and prescriber assessments. A review tier can be assigned to SACT protocols or to individual patients.

6.3 SACT protocols can indicate what tier(s) patients are usually in for that regimen and treatment indication at the start of treatment. Neoadjuvant and palliative SACT will require response assessments based on imaging and tumour markers; adjuvant treatments using the same drugs will usually require fewer assessments.

6.4 As the frequency of prescriber assessment will depend on previous toxicity and individual patient characteristics, each SACT protocol will usually need to specify a range of review tiers.

6.5 Patients can be assigned to a review tier for each cycle of SACT. Consider both the expected toxicity of the regimen and the individual characteristics of the patient before choosing a review tier for an individual patient. Important patient characteristics to consider include

- Performance status
- Frailty score
- Comorbidities including mental health
- Previous toxicities (including multiple G1/2 toxicities)
- Tolerance of previous SACT regimens
- Disease burden
- Psychosocial situation
- Individual patient preferences
- Ability to participate in a telephone review (eg hearing and speaking ability, whether English is the first language for the patient).

6.6 Consider changing tiers at each Fitness for Treatment Review. Patients will often move between review tiers during a course of treatment. The review tier for each patient should be recorded and should be clearly visible within the patient record.

	Tier A	Tier B	Tier C	Tier D	Tier E
Criteria	SACT with a high risk[1] of G2 or above toxicity **AND** patient has PS ≥2 or has had G3 toxicity or multiple (e.g. more than 3) G2 toxicities on a previous cycle.	SACT with a high risk[1] of G2 or above toxicity and patient has PS 0-1 with no G3 toxicity on a previous cycle **OR** SACT with a low risk[2] of G2 toxicity and patient has PS2 but not declining over previous month **OR** SACT with low risk[2] of G2 toxicity and patient is PS 0-1 and started this regimen in last 3 months	SACT with a low risk[1] of G2 or above toxicity **AND EITHER** patient has PS 0-1 and has been on this regimen for more than 3 months with no current G2 or above side effects **OR** patient has PS 2 but not declining and has been on this regimen for at least 6 months.	SACT with a very low risk[1] of G2 or above toxicity **AND** patient has PS 0-1 and has been on this regimen for more than 6 months with no G2 or above side effects and has no evidence of disease progression.	SACT concomitant with radiotherapy SACT concomitant with radiotherapy **AND** patient has PS 0-1 or PS 2 and not declining
Suggested example protocols	• FLOT neoadjuvant oesophago-gastric adenocarcinoma • TPF for H&N cancer • mFOLFIRINOX for pancreatic adenocarcinoma • Procarbazine, lomustine and vincristine for CNS tumours • Epirubicin and cyclophosphamide, and docetaxel for breast cancer	• Palliative capecitabine and oxaliplatin for UGI cancers • Pembrolizumab for H&N cancer • Adjuvant temozolomide for CNS tumours	• Maintenance trastuzumab after palliative SACT for UGI cancer • Adjuvant abemaciclib for breast cancer • Capecitabine for metastatic breast cancer	• Enzalutamide for prostate cancer • Pertuzumab/trastuzumab for breast cancer • Palbociclib for metastatic breast cancer	• Concomitant weekly cisplatin for head and neck cancer or cervix cancer • Concomitant capecitabine for upper gastro-intestinal cancer • Concomitant temozolomide for CNS tumours
Fitness for Treatment Review	Before each SACT cycle	Before each SACT cycle, usually by telephone	The minimum frequency should be specified in the protocol but a full review may not be required before every SACT cycle	The minimum frequency should be specified in the protocol but a full review will not usually be before every SACT cycle	Before each SACT dose, usually by telephone
Prescriber assessment	Before the next SACT dose, usually face to face	Every 3-4 cycles or at decision points as specified in the SACT protocol	Every 2-4 months or at decision points as specified in the SACT protocol	At decision points or at a minimum of every 6 months	At the start of treatment and at least once during the course of concomitant radiotherapy and SACT

1. Definitions of high, low and very low risk are difficult to specify and will vary with individual acceptance of risk. Suggested levels are
   a. high risk - 20% or more
   b. low risk - under 20%
   c. very low - under 5%

7. Examples

7.1 Prescribing for more than one cycle of CDK 4/6 inhibitors in Cheltenham

Once patients have received six cycles of palbociclib or abemaciclib for breast cancer (with or without fulvestrant), there is the option of generating a 12-week prescription. This is actioned for all patients who are clinically stable and when neutropenia has been grade 2 at its worst. The patients subsequently have blood tests and assessments every 12 weeks. The 12-week prescription avoids the need to generate a prescription to cover every cycle.

Prior to having the 12-week prescription available, clinicians found that even though they would have been happy to move the patient to a 12-weekly assessment schedule, they only had time in clinic to generate one prescription for each of these patients. This meant that although time was saved in the initial appointment by generating one rather than three prescriptions, patients were then coming back for assessment only four weeks later. Having the 12-week prescription option removes this inefficiency.

7.2 Prescribing for regimes with day 1, 8, 15 frequencies in Cheltenham

There is an SOP for patients to only be clinically assessed on day 1 of a SACT cycle, even when doses of treatment are due on day 8 or days 8 and 15. Patients still need to have bloods checked to ensure it is appropriate to give treatment on each of those days. Comprehensive clinical protocols are available on the Somerset, Wiltshire, Avon and Gloucestershire Cancer Alliance Network website, which provides parameters for patients to safely go ahead with treatment.

The prescriber assesses the patient on day 1 and prescribes day 1 plus day 8 and 15. The pharmacy team then checks the blood results are in range to proceed with day 8 and 15. The SACT nurses also check the blood results and assess toxicity on day 8 and 15 as part of the pre-chemo bedside checks.

Patient inclusion criteria

- Clinically well and stable at day 1 assessment
- Stable FBC and organ function comfortably in range
- Motivated patients who can be relied upon to get their bloods taken and will reliably attend their treatment appointment without prompting
- Regimen on approved list
- Cycle 2 onwards
- Not on a clinical trial

7.3 SACT NMP clinics in Belfast

Increasing demand for oral and subcutaneous breast SACT due to more indications and longer durations of treatment has encouraged clinics to develop SACT tiers in the form of specific treatment clinics managed virtually by NMPs. NMPs consist of trained pharmacists and nurse specialists. The use of virtual clinics became mainstream following innovations established during the Covid pandemic.

Once established on treatment, patients taking CKD4/6 inhibitors (eg ribociclib) or PARP inhibitors (eg Olaparib) have blood tests and dispensing every 3rd cycle (q4w). This allows a focused virtual SACT assessment between the 3 monthly complete assessment, which will often include restating imaging discussion. A clear escalation pathway exists to manage higher grade toxicity.

Subcutaneous SACT (eg trastuzumab) are normally managed by virtual clinics run by NMP with a mixture of home administration and “hub and spoke” centre administration. Trastuzumab is prescribed “en bloc” and “authorised” by nurse assessor using an assessment protocol. A clear escalation pathway allows for concerns to be addressed early.

Similar pathways exist for upper and lower gastrointestinal cancer regimens. Day 8 & 15 gemcitabine assessments and prescriptions were removed from “central” clinics and are managed by NMP virtual clinics. Maintenance checkpoint inhibitors and anti-EGFR SACT is managed by a virtual independent NMP clinic with consultant oversight and a clear escalation pathway.

7.4 Pharmacy technician enzalutamide reviews and verification in Oxford

In 2024, Oxford University Hospitals NHS Foundation Trust piloted a pharmacy technician undertaking mid ‘prescribing visit’ reviews for stable patients on enzalutamide. This was in response to the growing waiting list of more than 200 patients awaiting review. The technician was already trained and competent in clinical verification of enzalutamide prescriptions and undertook additional learning through the Guy’s Cancer Academy - Prostate Cancer Care for Advanced Non-medical Practitioners course as well as communication skills training and a period of supervised practice. The technician works alongside a non-medical prescribing pharmacist. A local treatment pathway and scope of practice was developed including a consultation checklist and escalation pathway.

Table 2: A schedule of a typical patient enzalutamide review pathway is as follows:

Pre-starting	Medical review - Consent and prescribing
Month 2	NMP Pharmacist - toxicity, symptoms and bloods review and prescribing
Month 3	Advanced Cancer Pharmacy Technician - toxicity, symptoms and bloods review
Month 6	Medical review or NMP Pharmacist - toxicity, symptoms and bloods review and prescribing (six months)
Month 9	NMP Pharmacist or Advanced Cancer Pharmacy Technician - toxicity, symptoms and bloods review
Month 12	Medical review - toxicity, symptoms and bloods review and prescribing (six months)

7.5 Cardiff Virtual Assessed Pathway (VAP) Clinic

In 2020 Velindre Cancer Centre set up the VAP Clinic - a multi-cancer site, independent prescriber (IP) led SACT assessment clinic to manage the increasing demand for SACT assessment and prescribing. Staffing the VAP Clinic are a team of IPs who each have two cancer sites within their scope of prescribing and SACT reviewers who telephone the patients two days before their treatment. The SACT reviewers, who are mainly former SACT nurses or pharmacy technicians, complete a regimen specific fitness to treat checklist and the IP prescribes treatment with reference to this.

By completing the fitness to treat review two days before treatment rather than on the day, any dose reductions, addition of supportive meds or deferrals can be acted on in a timely fashion, avoiding drug or SACT chair wastage. Bloods are taken near to the patients, usually in their local hospital.

By utilising former SACT nurses, eg those who have retired and returned, are pregnant or are unable to do the 12 hour shifts on the SACT Units, the NHS retains their expertise. Pharmacy technicians are also an untapped but highly useful group of practitioners who can be trained to complete a clinically comprehensive fitness to treat review, which in turn helps with the recruitment and retention of this cohort of traditionally difficult to recruit professionals.

Each IP spends 50% of their job plan working in consultant clinics to maintain clinical competency and the rest of their time in the VAP clinic. To date VAP has undertaken over 20,000 fitness to treat reviews. This clinic enables clinical prioritisation so Consultants can concentrate on seeing more complex patients.

The example checklist in Appendix 1 uses elements from both the UKONS checklist and CTC AE v5 depending on which system is less subjective and more structured. It has been rewritten in non-medical language so patients can use it during the phone call which forms the fitness to treat review.

8. Acknowledgements

8.1 About the UK SACT Board

The UK SACT Board provides guidance, oversight and support for the continuing development of SACT services in the UK. Its core membership comprises representatives of the Association of Cancer Physicians, The Royal College of Radiologists, the Royal College of Physicians, the British Oncology Pharmacy Association and the UK Oncology Nursing Society. The Board also has representation from the four UK nations, a patient representative and from other organisations closely involved in SACT services.

8.2 About this guidance

The UKSB would like to thank the following members of the Working Group for preparing this guidance:

- Dr Tom Roques (chair) - Consultant clinical oncologist, Norfolk and Norwich University Hospitals NHS Foundation Trust; Vice-President, Clinical Oncology, Royal College of Radiologists.
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- Joseph Williams – Pharmacist, The Christie NHS Foundation Trust; UK SACT Board co-chair 2025

8.3 Disclaimer

This material has been produced by the UKSB for use internally within the specialties of clinical oncology and medical oncology, and by other specialties and healthcare professionals involved in the care of adult patients with cancer in the United Kingdom. It is provided for use by appropriately qualified professionals, and the making of any decision regarding the applicability and suitability of the material in any particular circumstance is subject to the user's professional judgement.

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9. Useful resources

Guidance for the safe delivery of systemic anti-cancer therapy. Scottish Government Cancer Policy Unit, 2023

Prescriber competencies for reviewing and prescribing systemic anti-cancer therapy. UK SACT Board 2023

Guidance on the contents of a SACT protocol. UK SACT Board 2025

Appendix 1: Example checklist

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VAP Service Clinic checklist – CRC

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Deferred Date:	**Prescribers Comments:** **Assessment comments**	**Blood Day:** **SACT Day:** **Confirmed?**

Patient Name:			**Any contact with the treatment helpline? Yes ☐ No ☐** **or any issues on the last administration (if IV)**
V Number:			**Scan booked? If not, has email been sent to remind Team? ☐** **Yes ☐** Date of Scan: _____ **No ☐ N/A ☐ Requested ☐**
Consultant:	**Regimen:** **Date**	**Met ☐** **Adj ☐** **Neo ☐**	**If scan booked, is results clinic booked? Yes ☐ N/A ☐** **If no result clinic - has email been sent? Yes ☐ N/A ☐**
Assessor:	**Rebooked to VAP ☐ Clinic ☐**		**Tumour Marker (use previous cycle if within 1 month if results not back)** **N/A ☐ Lower ☐ Stable ☐ Higher ☐**

Toxicity (circle grade)	**Grade 0**	**Grade 1 (Mild)**	**Grade 2 (Moderate)**	**Grade 3 + 4 (Severe)**
Nausea (feeling sick)	None	Feeling sick but able to eat almost as normal	Able to eat and drink but much less than normal	Eating and drinking nothing.
Vomiting (being sick)	None	1-2 episodes in one day	3 - 5 episodes in one day For How many days _____	6 or more episodes in one day For How many days _____
Diarrhoea	None	More than 3 episodes of diarrhoea per day over what is normal for me or a mild increase in loose waters motion if you have a colostomy.	More than 4 - 6 episodes of diarrhoea/day more than is normal for me or moderate increase with a stoma. How many days?	More than 7 episodes of diarrhoea per day over normal making me feel unwell. Severe increase in loose waters stools with a stoma
Constipation	None	No bowel motion for 1 day **longer than normal** - or constipation that is under control by using anti-constipation meds.	No bowel motion for 2 or so days **longer than normal** and making me feel unwell. **How many days?**	No bowel motion for 3 or so days **longer than normal** or with severe stomach pain
Mouth soreness	None	Painless ulcers Able to eat and drink	Painful mouth but still able to eat and drink.	Painful mouth. Eating and drinking very little or none as a result
Skin on Hand/feet (Palmar Plantar Syn)	None	Some redness or dryness but no pain splitting or cracking.	Skin is painful, bleeding or peeling, blistering, cracking or swelling.	Severe skin changes with pain and symptoms of peeling/ blistering/severe cracking/swelling.
Rash	None	Small area of rash that is not painful	A rash that has pus filled spots or a rash covering up to a third of my body. It is itchy / painful. Affects my sleep/ mood	Painful /itchy rash or pus filled spots / ulcers / infection covering a **large** area of my body. Unable to do anything because of this rash.
Altered sensation in hands / feet (Peripheral Neuropathy)	None	Mild tingling or numbness in fingers, toes and / or the soles of my feet lasting only a few days then settles.	Tingling or numbness or pain lasting 10- 14 days. More difficult to do some normal activities like texting or doing up buttons.	Tingling or numbness in fingers, toes, soles of feet that is there all the time. Tripping or dropping things. Unable to carry out normal activities.
Fatigue (tiredness)	None	Feeling tired but still able to carry out most normal activities as long as I rest after.	Tired/ fatigued most of the time despite resting. Not able to cook/ shop or do much for myself but up and about > 50% of the day.	Very low energy, too tired to do almost anything despite resting. In bed most of the time.
Mood/ Feelings	OK	OK, a bit up and down at times.	Sad/ anxious/ upset most of the time. Not coping a lot of the time.	Really sad/ anxious/ upset all of the time. Not coping at all.

Follow-up questions	Notes	Tick as appropriate
Any weight loss or gain? If so, comment. (Needs weight every three months). *If weight loss experienced, is this intentional? Discuss appetite.*		**Yes** ☐ **No** ☐
Any other problems/symptoms not mentioned on toxicity sheet such as any signs of infection?		**Yes** ☐ **No** ☐
Has the patient attended any unplanned hospital or a medical appointment since their last SACT?		**Yes** ☐ **No** ☐
Has the patient started any new medication either prescribed or OTC?	If so what is it	**Yes** ☐ **No** ☐
Are there any relevant bloods/results on ETR Check why if taken between SACTs		**Yes** ☐ **No** ☐
If PICC Line in situ, check if any concerns		**Yes** ☐ **No** ☐ **N/A** ☐
Do they need blood forms? *** If yes, state quantity and bloods required on OON ***		**Yes** ☐ **No** ☐
Check patient is aware of date and time of SACT	Date: Time:	**SACT appointment confirmed** ☐
Inform patient of date of next Clinic		**Next clinic appt. confirmed** ☐
Patient preference for next VAP Call		**Phone** ☐ **Video** ☐ (if video, please note on the anno of their ***next*** appt)

Post-assessment Critical Blood Results

Are all **Critical** Blood Results within range? Bili Alk Phop + ALT Creat Neutrophils + Platelets		*Indicate if any outside range*	**Yes** ☐ **No** ☐
Other Bloods:	Creatinine	*Check for AKI warning/ doubled*	**Yes** ☐ **No** ☐
	Magnesium ≥0.7		**Yes** ☐ **No** ☐
	Haemoglobin ≥ 90		**Yes** ☐ **No** ☐
	Tumour marker	*Complete box at top of front page.*	**Yes** ☐ **No** ☐ **N/A** ☐