

Adult Form



Palliative Care Assessment

Admission date:		Discharge date:							
PC referral date:			Re-admission date:						
PC assessment date:			Date of death:						
Referring ward			Place of death:						
Consent to be part of database? yes no			unable Reason:						
Referring doctor:			Responsible pc member:						
Doctor's mobile no.:			PC member's mobile no.:						
Doctor's email:			PC member's email:						
PATIENT INFORMATION (place s	ticker or complete in	nformation)							
Folder number:			Date of birth:						
Surname:			Contact number:						
First name:		Home language: Gender:							
Address:									
NEXT OF KIN INFORMATION (ple	ease complete as de	etailed as pos							
Folder number:			Relation to patient						
Contact no 1:			Contact no 2:						
Physical address:									
B.C. and Land									
Referral location:	.	_							
□ Surgery □ OB/Gynae	□ Orthopaedics		auma		□ ED				
□ Medical □ Renal clinic	☐ Medical Outpat	tient □ Su	urgery outpatient	☐ Oncology	□ Other				
Reasons for referral:									
_	Other symptom m	~	☐ Home base care	☐ Syringe dri					
<u>-</u>	Counselling for pa	atient/family	□ Education	☐ Hospice ref	erral/discussion				
☐ Other:									
Primary diagnoses:									
□ Cancer (solid tumour)	□ Va	scular	□ Infectious/TB/HI	V □ Ha∈	ematology Frailty				
□ Neurologic/stroke	□ H	epatic	□ Cardiovascular □ Trauma						
☐ Progressive neurological conditions ☐ Pulmonary			□ Renal □ Dementia						
□ Other:									
History:									
FCCC markerman a status.	d/mahila)			Cully Da	alle e consul				
ECOG performance status:	1(mobile)	2	3	Fully Be	abouna				
Mental status:	Orientated	Confuse	d Unconscious	s Sluctua	ting GCS				
Patient understanding diagnosis	yes	no	Understanding pr	rognosis	yes no				
Family informed	yes	$=_{no}$							
Symptom/Needs Assessment									
• •	Neterment	Nagativa	Danitiva	Crada	Astion Taken				
Needs / Symptoms	Not screened	Negative	Positive	Grade	Action Taken				
Pain				(Scale)					
Non-pain symptoms									
Psychological needs									
Social									
Economic									
Spiritual									
Family support									
Scale Key: None: 0 Mild: 1	Moderate: 2	Severe	e: 3 Not asses	sed: 7 Una	ble to rate: 9				

PC Team's Contact Person:

PC Team's Contact number:

Contact email:



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Problem list and daily visits									
Date	Problem			Action Taken					
/									
/_									
/									
/									
/									
/									
/									
/									
/									
/									
Family meetings									
/	PC team member:			Treating team member:					
/	Total family present:			Responsible person					
Education provi	ded	BBN Counselling Future Care		Future Care	Follow up				
Notes:									
Team member/s involved:									
Comments									
			Discharge						
Date of discharg	e:		-						
Mediation Dose		Place of Discharge (please tick most appropriate)		Services referred to (please tick most					
		Home		appropriate) Home base					
		Extended family		Clinic-based PC					
			Intermediate Care Facility		Hospice				
			Hospice	<u> </u>		Home-based PC			
		Frail care		Other					
		Hospital in-patient			None				
Person contacted Date		Contact Number		Method & Regularity (eg. Weekly whatsapp)					
						,			

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