Date:_____

Patient name_____ Birth:_____ Hospital#_____

Referral Source:_____

CC: Palliative Care Consult: *(pain/symptoms/goals of care/quality of life).*

HPI: _____

_____

_____

_____

_____

_____

_____

*Medical/Surgical History*_____

_____

_____

_____

Current Medications _____

_____

_____

_____

Allergies: _____

Review of Symptoms

Pain_____

Nausea/Loss of Appetite_____

Constipation/diarrhea_____

Drowsiness/Loss of energy_____

Dyspnea/Secretions_____

Depression/anxiety_____

Delirium_____

*Social History*_____

_____

_____

_____

*Psychological History*_____

_____

_____

Spiritual _____

Cultural _____

Legal/
*Ethical*____

____

Physical exam

Code Status: Yes No Modified

Palliative Performance Scale:
Prognosis:

Impression/Plan:

Laboratory data/tests:

Diagnosis/plan:

Thank you for the opportunity to participate in the care of this patient. We will continue to follow.

Total time:
- Chart review
- Face to face
- Documentation/coordination of care