



MINISTRY HEALTH CARE PALLIATIVE CARE CONSULT SHEET

Name: \_\_\_\_\_
MRN: \_\_\_\_\_
DOB: \_\_\_\_\_
Sex: \_\_\_\_\_
Admit Date: \_\_\_\_\_
PCP: \_\_\_\_\_

SEH MMC SMH MSCH MSMH HYMC MSJH

Consult Details: Date \_\_\_\_\_ Time \_\_\_\_\_ Location \_\_\_\_\_ Referring MD/Service \_\_\_\_\_

Reason for Consult: Pain Mgt. Symptom Mgt Advance Care Planning Review Treatment options/Prognosis Discussion Hospice Evaluation/Discussion Withdrawal of life-sustaining therapies Patient & Family Support (Psychological/Spiritual) Other: (please provide details) Advance Directives: Living Will POA Healthcare Rep. Code Status: Full Code DNR DNI CMO

HPI: (location, quality, severity, duration, timing, context, modifying factors, assoc. signs/symptoms)

PMH/PSH:

Current Medications:

Allergies:

Family History: Mother \_\_\_\_\_ Father \_\_\_\_\_

Siblings \_\_\_\_\_

Social History: Please include details of Military Experience, Hobbies and Activities patient Enjoys (such as Travel below)

Marital Status Single Married Divorced Separated Widowed Work Details: Employed Unemployed Disabled Retired

Resides at: Home ALF SNF If at Home, Any Home Care Services Yes No Primary Caregiver:

EtOH \_\_\_\_\_ Tobacco \_\_\_\_\_ Other \_\_\_\_\_

ROS: Current Symptoms: ESAS\* (0-none, 1-mild, 2-moderate, 3-severe; If moderate to severe, describe.)

Source: Patient Family Team (Select all that apply) Unable to obtain due to poor mental status.

Pain\*Severity 0-10 Fatigue/Tiredness\* Nausea\* Depression\* Anxiety\* Drowsiness\* Anorexia/Appetite\* Well Being\* Dyspnea/SOB\* Diarrhea Constipation (Last BM)

- Agitation                       Insomnia                       Physical Discomfort                       Other

Dementia:  Yes  No, If Yes, [FAST Score](#) \_\_\_\_ Delirium:  Yes  No Activity level:  Very Active  Some Activity  Minimally Active  Not Active  N/A [PPS](#) \_\_\_\_\_

#### PSYCHOSOCIAL

- a. What/Who do you want to know about your health?  
\_\_\_\_\_
- b. Finances/Insurance Coverage:  
\_\_\_\_\_
- c. Family support: (Important / depend on / confide in)  
\_\_\_\_\_
- d. Patient/family Coping: (strengths, resources, past exp., support groups)  
\_\_\_\_\_

#### CULTURAL-SPIRITUAL

- a. Tell me about yourself (Born and raised in?) \_\_\_\_\_ Language preference \_\_\_\_\_
- b. Have you had difficulty coping with your situation/illness \_\_\_\_\_
- c. Do you feel you are at peace in your life right now?  
\_\_\_\_\_
- d. Role of faith/spirituality? Chaplain visits?  
\_\_\_\_\_

#### PHYSICAL EXAM:

Vital Signs: BP \_\_\_\_\_ P \_\_\_\_\_ RR \_\_\_\_\_ T \_\_\_\_\_ O<sub>2</sub> Sat \_\_\_\_\_ %

**General Appearance:**  Comfortable  Pain: Score (0-10) \_\_\_\_ Location \_\_\_\_\_ **Eyes:**  PERRLA  EOMI  Sclera WNL  Other: \_\_\_\_\_ **ENMT:**  Hearing Intact  Ears, Nose, Pharynx WNL  Moist Mucous Membranes  Nasal Drainage  Poor dentition  Edentulous  NGT  Other: \_\_\_\_\_ **Neck:**  Supple  Full ROM  No masses  Trachea Midline  Thyromegaly/Thyroid Mass  Lymphadenopathy  Nuchal Rigidity  Other: \_\_\_\_\_

**Respiratory**  Excursion/Motion/Resp. Effort WNL  CTA B/L  Crackles R/L  Wheezes R/L  Incr. WOB  Other: \_\_\_\_\_

**Cardiovascular:**  RRR  No M/R/G  Radial Pulses 2+ symmetric  Pedal pulses WNL  No pedal edema  No cyanosis  No carotid bruits  JVD Normal  Murmur S/D  Irregular Pulse  Tachycardia  Bradycardia  LE Edema 0 1+ 2+ 3+  Cool extremities  JVD elevated  Other: \_\_\_\_\_

**GI/Abd:**  Soft  NT/ND  No guarding/rebound  BS normal/+  Abdominal Pain: \_\_\_\_\_  Obese  Distended  PEG

Other: \_\_\_\_\_ Digital Rectal Exam:  WNL  Hemorrhoids  Bleeding

**GU:**  External Genitalia WNL  Foley Catheter  Suprapubic Catheter  HD/PD Catheter  Voids  CVA Tenderness  Suprapubic Tenderness  Other: \_\_\_\_\_

**Neurologic:**  A/O x 3  Grossly Non Focal  CN's 2-12 Intact  Focal Motor Deficit  Sensory Loss  Seizure  Other: \_\_\_\_\_

**Musculoskeletal:**  Strength/Tone/ROM WNL  No contractures  NI Muscle Strength  Muscle atrophy  Arthritis

Back Pain  Global weakness  Other: \_\_\_\_\_

**Skin/Integumentary:**  Intact Grossly/No lesions  Good color  Rash  Ulcer  Venous Stasis  Wound dressed  Cellulitis  Other: \_\_\_\_\_

**Heme/Lymph:** \_\_\_\_\_

**Psychiatric:**  Normal Affect  Judgement & Insight impaired  Anxious  Depressed  Lethargic  Stuporous  Comatose

Agitated  Other: \_\_\_\_\_

#### Labs, Imaging & Other Diagnostics:

**Prolonged Discussion:**  The patient was present.

Other Participants:

Assessment/Plan/Impression/Recommendations:

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Plan discussed with family:  Yes  No

Plan discussed with Primary Team:  Yes  No

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Total Time Spent:  
\_\_\_\_\_