



PALLIATIVE & END OF LIFE CARE PROGRAM CLIENT PROFILE (2.91)

Name: _____ CRMS#: _____

Diagnosis: _____

Is client aware of prognosis? Yes No Is family aware of prognosis? Yes No

Comments: _____

NOK: _____ Relationship: _____

Substitute Decision Maker (if applicable): _____ Tel#: _____

Admission date to EOL Program: _____

	Admission Date:	Reassessment Date:	Reassessment Date:	Reassessment Date:
PPS	_____	_____	_____	_____
ESAS	_____	_____	_____	_____

Attending Physician:	Tel #:
CCNC:	Tel #:
CSSW:	Tel #:
Palliative Care Consultant:	Tel #:
Grief & Bereavement Consultant:	Tel #:

Documentation		Comments (ex: list equipment, agency name, dates, # of hours, etc.)
DNR	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Advance Health Care Directive	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Order for RN to Pronounce or Paramedic to Determine Death Form for Pronouncement/ Determination of Death	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Order for RN to complete death certificate	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Funeral home notified	<input type="checkbox"/> Yes <input type="checkbox"/> No	
EOLHC Equipment provided	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Home Support Services: Regular Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency: _____ Hours: _____ Date: _____
Home Support Services: EOLHC Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	Agency: _____ Hours: _____ Date: _____

Medications:

Solis CADD Pump being used?: Yes No

Additional information:

- CCNC to obtain all medications/pump/key/etc. and return to pharmacy
- the pronouncement/determination of death form can be found on the Intranet:

NOTIFY VANESSA HOUSE WHEN A CLIENT HAS BEEN ADMITTED TO HOSPITAL OR DECEASED