### Sample Palliative Care Consultation/Evaluation Template

Using a template facilitates comprehensive documentation that captures the complexity of palliative care evaluation and demonstrates the high level of assessment that an APRN performs during an initial evaluation. The following template offers important areas to highlight and document the comprehensive and complex services that the hospice and palliative APRN provides.

<table>
<thead>
<tr>
<th>Name of Patient:</th>
<th>Medical Record Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
<tr>
<td>Date of Admission into Hospital/Hospice/Home Health/Skilled Facility:</td>
<td></td>
</tr>
<tr>
<td>Admitting Physician:</td>
<td>Attending Clinician:</td>
</tr>
<tr>
<td>Referring Clinician:</td>
<td>Reason for Consultation:</td>
</tr>
<tr>
<td>Date of Evaluation/Consultation/Visit:</td>
<td>Palliative APRN Consultant:</td>
</tr>
</tbody>
</table>

**HISTORY (ELEMENTS)**

Subjective/Chief Complaint

Reason for Admission/History of Present Illness

State who provided history or where history obtained

**Symptom Review**

Location:

Quality:

Severity:

Duration:

Timing:

Context:

Modifying or Exacerbating Factors:

Associated Signs and Symptoms:
PAST MEDICAL HISTORY

FAMILY MEDICAL HISTORY

Diseases, conditions, illnesses by specific blood relatives:

Specific to patient condition:

SOCIAL HISTORY

Marital status:

House location and dwelling:

Family composition:

Employment status:

Insurance status:

Education:

Social Coping

Patient coping:

Support system:

Family support:

Family coping:

Hobbies/Joys:

HABITS

Tobacco use: Yes | No | None – distant history and when d/c’d:

Alcohol use: Yes | No | None – distant history and when d/c’d:

Recreational drug use: Yes | No | None – distant history and when d/c’d:

Illicit Medication use: Yes | No | None – distant history and when d/c’d:
PALLIATIVE CARE PAIN AND SYMPTOM REVIEW

Pain or Symptom History:

Pain or Symptom Description:

Pain or symptom intensity (0-10):

Interference with daily life (0-10):

Worst it’s been in last two weeks (0-10):

Best in the last two weeks (0-10):

Medications used and success or failure of them:

PALLIATIVE REVIEW OF SYSTEMS (circle or underline symptoms that are present)

Constitutional: Denies | Anorexia | Drowsiness | Fatigue | Fever | Weight Loss

Eyes: Denies | Dry eyes | Excessive tearing

Ears, Nose, Mouth, Throat: Denies | Secretions | Xerostomia

Cardiovascular: Denies | Chest pain | LE swelling

Respiratory: Denies | Dyspnea | Cough

Gastrointestinal: Denies | Nausea | Vomiting | Abdominal pain | Constipation | Diarrhea

Genitourinary: Denies | Urinary retention | Urinary incontinence

Musculoskeletal: Denies | Bone pain | Joint pain | Muscle pain

Skin: Denies | Pruritus | Decubitus ulcers | Dry skin | Rash

Neurological: Denies | Delirium | Agitation | Sedation

Psychiatric: Denies | Anxiety | Depressed mood | Hallucinations

Endocrine: Denies | Steroid side effects | Cold/heat intolerance

Allergic/Immunologic: Denies | Immunosuppression | Neutropenia

Hematological/Lymphatic: Denies | Bruising | Bleeding | Lymphedema | Lymphadenopathy

All other systems reviewed and are negative.
PALLIATIVE REVIEW OF ADVANCED DIRECTIVES

Surrogate Decision-Maker:

Location of Surrogate Decision-Maker Document:

Durable Power of Attorney:

Advanced Directives/Living Wills:

Location of Advanced Directives/Living Wills:

Attitude towards place of death: home | other:

Funeral arrangements/wishes:

INFORMATION SHARING

Patient’s awareness of illness:

☐ Serious ☐ Not life-threatening ☐ Not serious ☐ Not discussed

Information preferences:

☐ Unsure ☐ Fully involved ☐ Speak/Defer to family

☐ Leave to Healthcare team (MD/APRN)

Family awareness of illness:

☐ Terminal ☐ Life-threatening

☐ Serious ☐ Not life-threatening ☐ Not serious ☐ Not discussed

RESUSCITATION STATUS

☐ No chest compressions ☐ No antiarrhythmics

☐ No defibrillation or electrocardioversion ☐ No artificial nutrition/hydration

☐ No endotracheal intubation ☐ No antibiotics

☐ No mechanical ventilation ☐ No blood draws

☐ No non-invasive ventilatory support (BiPAP, CPAP) ☐ No re-hospitalization

This template is a supplement the resources book, A Primer for Billing, Reimbursement, and Coding - An Essential Resource for Hospice and Palliative APRNs, and can be freely copied.

OUT OF HOSPITAL MEDICAL ORDERS IN PLACE TO REFLECT RESUSCITATION STATUS:  Yes | No

(These are often known as Physician/Provider Orders for Life-Sustaining Treatment [POLST]; Medical Orders for Life-Sustaining Treatment [MOLST]; or Out of Hospital Code Status or Comfort Care Orders)

SPIRITUAL HISTORY

Religious/Spiritual Orientation:

Involvement in Spiritual Community:

Use of Spiritual Leader:

Wish/Need for further chaplaincy support:

OBJECTIVE/PHYSICAL EXAM

Vital signs:  T  HR  RR  BP  O₂Sat

General appearance:  Development, nutrition, body habitus, attention to grooming, deformities

Eyes:  PERRLA, EOMI, vision intact, sclera clear

Ears, Nose, Mouth, Throat:  Hearing; Examination of mucosa, teeth, and gums; moistness; color; Appearance of thrush; Neck appearance, glands, and masses; Thyroid examination

Cardiovascular:  RRR  |  S₁S₂  |  Presence of murmurs  |  Rubs  |  Pulses  |  Pedal edema

Respiratory:  Breath sounds  |  Audible throughout  |  Respiratory effect

Gastrointestinal:  Bowel sounds present  |  Soft, non-tender  |  No HSM  |  No rebound

Presence of ostomy or tubes  |  Presence of hernia  |  Rectal exam as appropriate

Genitourinary:  Inspection of external genitalia with no abnormalities noted

Presence of nephrostomy tubes

Heme/Lymphatics:  Neck  |  Axillae  |  Groin  |  Bruising

Musculoskeletal:  Gait intact  |  Joint deformities  |  Strength grossly intact  |  No pain on palpation

Skin:  Rashes  |  Sores  |  Bruises

Neurologic:  CN II-XII grossly intact  |  Strength and reflexes symmetrical

Psychiatric:  Orientation to person, place, and time; Memory, mood, and affect
LABORATORY AND RADIOLOGY: State which laboratory tests and radiological examinations were reviewed and any pertinent findings.

IMPRESSION: Age and gender of patient, pertinent symptoms with differential diagnosis.

RECOMMENDATIONS/PLAN: Separate out by symptom to demonstrate the complexity of decision-making and management. Include Advance Care Planning, Goals of Care, and Discharge Planning as separate recommendations.

Thank you for consulting us on this interesting patient. We will continue to follow with you.

Please call us with any questions at Quality Palliative Care, Telephone #: xxx-xxx-xxxx.

Start time: Finish time: Total time:
Time spent counseling: Counseling topics:
APRN Signature with credentials:
Printed name: Pager number:

KEY
APRN – advanced practice registered nurse
d/c’d – discharged or discontinued
BiPAP – bilevel positive airway pressure
BP – blood pressure
CN – cranial nerves
CPAP – continuous positive airway pressure
EOMI – extraocular movements intact
HR – heart rate
HSM – hepatosplenomegaly
LE – lower extremity
MD – Doctor of Medicine
O₂Sat – oxygen saturation
PERRLA – pupils equal, round, reactive to light and accommodation
RR – respiratory rate
RRR – regular rate and rhythm
S₁S₂ – 1st & 2nd heart sounds
T – temperature

d/c’ed – discharged or discontinued

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