Griffith Area Palliative Care Service

PATIENT HELD RECORD

PALLIATIVE CARE ADMISSION

SURNAME.................................MRN ....

GIVEN NAMES..

DOB.....................................GENDER ....

ADDRESS ....

....

Indigenous Status:	Religion:	Financial Election:
Country of Birth:	Marital Status:	Veterans' Card No:
Home Phone:	Medicare No:	DVA Card Colour:
Work Phone:	Primary Language:	DVA Approval No:
Mobile:	Interpreter Required: Y/N:	Ambulance Fund: Y/N

Doctor:	Accom Status: Lives in residential care facility ❍
Date of First Diagnosis:	Lives with another ❍ Lives alone ❍
Principal Palliative Care Diagnosis:	Carer Availability: Always Available ❍ Limited ❍ Not Available ❍

Other Significant Diagnosis:

Metastases:

Date of Referral:

PC Phase at this time: Stable ❍ Unstable ❍ Deteriorating ❍ Deteriorating ❍

Referral Source:

Preferred Place of Terminal Care: Home ❍ Hospital ❍

Reasons for Referral:

Symptom Control ❍ Terminal Care ❍ Home Care ❍ Respite ❍

Home Care ❍ Opinion/Information ❍ Other Services ❍

History of this illness:

Past Medical History:

Medication on Admission:

Pharmacy:	Patient's/Family Insight:
Patient/Family Wishes Regarding Further Treatment:	
Spiritual Needs:	Funeral Arrangements:

CONSENT FORM FOR
GRIFFITH AREA PALLIATIVE CARE SERVICE

Please ensure the client, carer, advocate or legal guardian reads each section carefully and signs where indicated. In the instance where the client is unable to read, they must have each section explained before signing utilising the services of an interpreter where necessary. If **informed** consent cannot be obtained, indicate this in the appropriate area at the bottom of the page. The client should indicate in the box provided using a tick (✓) those issues to which he or she consents.

I ....*(full name)*

on behalf of myself or ....*(full name)*

of ....*(address)*

Hereby agree to be a participant in

1. ❍ Griffith Area Palliative Care Pilot Project
2. ❍ Multidisciplinary Care Plan
3. ❍ Multidisciplinary Case Conference
4. ❍ Patient Centred Health Care Record

I understand that Case Conferences and Care Plans will involve people who are professionally associated with me and will discuss my case, develop and document strategies aimed at assisting me.

I agree for the following people/organisations to obtain/release information regarding my case for the purpose of Case Conferences and Care Plans:

General Practitioners, Medical/Nursing Specialist,
District/Community Nurse, Community Health, Home Care Service,
Pastoral Care, Griffith Nursing Service, Volunteer Services.

While my record is kept in my home, I take responsibility for making it available to those who need to know about my condition. I understand that my record remains the property of the Griffith Area Palliative Care Service and I agree to return it when I cease to receive treatment or care from the Griffith Area Palliative Care Service upon request.

I understand that I am able to withdraw consent at anytime and that this will not affect my care

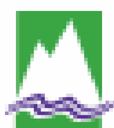
Signature ....(patient/Client/Agent) Date ....

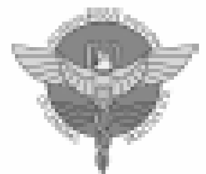
Signature..(witness) Date ....

I have not been able to obtain informed consent relating to sections (s)......................indicate which section(s))

from, or on behalf of .... (client's name)

Print name...Signature... Date.............................





GAPS: CONSENT V.1.0

SYMPTOM ASSESSMENT SCALES

SURNAME..MRN ....

GIVEN NAMES...

DOB...GENDER ....

ADDRESS ....

....

ASSESSMENT DATE								
PHASE OF CARE S-Stable U-Unstable D-Deterioration T-Terminal								

Mark the line corresponding to the number indicated by the patient 0 - None................10 Worst possible.

1	INSOMNIA								
2	APPEPITE PROBLEMS								
3	NAUSEA								
4	BOWEL PROBLEMS								
5	BREATHING PROBLEMS								
6	FATIGUE								
7	PAIN								
8	QUALITY OF LIFE								
9	SATISFACTION WITH QL								
10	OPTIONAL UNLISTED SYMPTOMS								
11									
12									
13									
	ASSESSOR Signature/Name/Designation								

Assessor: P - PATIENT N - NURSE F - FAMILY CARER

GRIFFITH AREA PALLIATIVE CARE SERVICE
Functional Assessment - Karnofsky and RUG-ADL Scores

SURNAME..................................MRN ....
GIVEN NAMES..
DOB..................................GENDER ....
ADDRESS...
....

Date								
Karnofsky Score								

Rating (%)	DEFINITION
100	Normal; no complaints; no evidence of disease.
90	Able to carry on normal activity; minor signs or symptoms
80	Normal activity with effort; some signs or symptoms of disease.
70	Cares for self; unable to carry on normal activity or to do active work.
60	Requires occasional assistance but is able to care for most of own needs.
50	Requires considerable assistance and frequent medical care.
40	In bed more than 50% of the time.
30	Almost completely bedfast.
20	Totally bedfast and requiring extensive nursing care by professionals and/or family.
10	Comatose or barely rousable.

RUG ADLs								
Bed Mobility 1 - 3 - 4 - 5								
Toileting 1 - 3 - 4 - 5								
Transferring 1 - 3 - 4 - 5								
Eating 1 - 2 - 3								
AAHPC SCORES								
Pain 1 - 2 - 3 - 4								
Other Sympt. 1 - 2 - 3 - 4								
Psy/Spiritual 1 - 2 - 3 - 4								
Family Carer 1 - 2 - 3 - 4								

BED MOBILITY/TRANSFER

1. Independent
3. Limited Assistance
4. Other than 2 person physical assistance
5. 2 Person physical assistance

EATING

1. Independent
2. Limited Assistance
3. Extensive/Total Dependence

AAHPC SCORE

1. Absent
2. Mild
3. Moderate
4. Severe

RUG ADLs and AAHPC 1 - None.......................4 - Extensive Assistance

Assessor Signature/Name/Designation)								

Assessor P - Patient N - Nurse F - Family Carer

Filling in the

GAPS

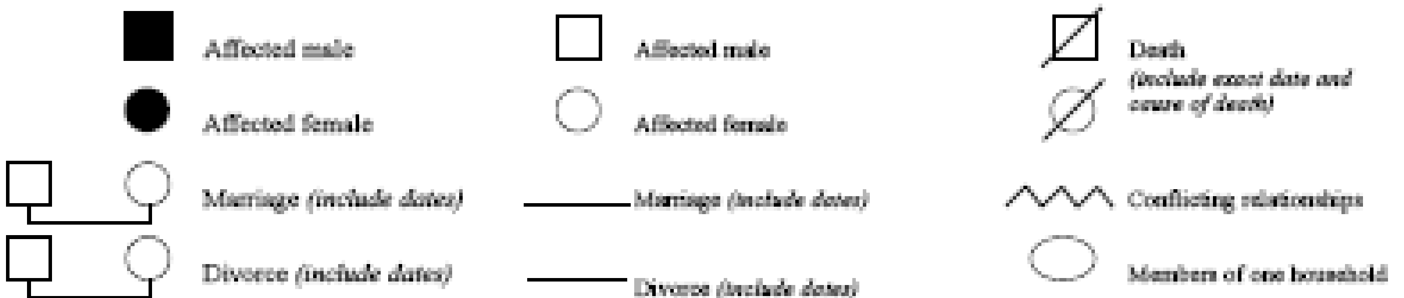
GRIFFITH AREA PALLIATIVE CARE SERVICE

Disclaimer:
*This tool is only a **guide** and **does not** replace clinical judgement*

U.R. No		LMO	
Surname			
Given names			
Address			
		Phone	
Sex		Age	
DOB	/ /		

(Or attach Client ID Label)

GENOGRAM



Adapted from DVA Palliative Care Clinical Pathway

GRIFFITH AREA PALLIATIVE CARE SERVICE
Home Visit Environmental Checklist

SURNAME.......................................MRN ....

GIVEN NAMES...

DOB.......................................GENDER.........................

ADDRESS ....

....

HOME LOCATION DETAILS	YES	NO	N/A
• Visible house number?			
• Front Light?			
• Telephone connected?			
• Is the main entrance at front of the house?			
• Nearest cross street?			

If it is a unit or a farm how is it reached?: ....

....

....

....

HOUSING OCCUPANTS	YES	NO	N/A
• Is there a carer/support person in the home?			
• Any evidence of domestic violence issues?			
• Will other people be present in the home - how many?			
• Has the patient adequate English to understand English?			
• Is transport available?			

HAZARDS	YES	NO	N/A
• Problem pet - dogs etc?			
• Is patient aware to restrain?			
• Any other hazards?			

Name:..Designation: ....

Signature:..Date: ....