Palliative Care Case Conference

Summary - Home Care

Organisation:

Full name of client: _____

DOB (dd/mm/yy): _____

Purpose of Case Conference: _____

Client consent/substitute decision-maker (SDM) consent

My care provider has explained the purpose of a case conference and I give permission for my care provider to prepare a case conference. I give permission to the providers listed below to participate in the case conference and discuss my/my family member's medical history, diagnosis, and current needs.

Signature: _____

Date: _____

Dial-in telephone number: _____ **Code:** _____

Client in attendance? Yes ☐ No ☐ **If no, give reason:** _____

Family Members		
Name	**Relationship**	**Attending in person (P) or teleconference (T)**
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T

Health and Care Professionals		
Name	**Discipline/Position**	**Attending in person (P) or teleconference (T)**
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T
		☐ P ☐ T

Palliative Care Case Conference

Summary - Home Care (continued)

Start time: _____

Need (as appropriate): _____

Key Issues	Description
Advance care plan Does this need to be reviewed? Does the person understand their diagnosis/prognosis?	
Symptoms For example: fatigue, anorexia, pain, nausea, dyspnoea, dysphagia	
Social/psychological needs For example: isolation, anxiety, depression What supports are being provided? What supports are needed?	
Assessments/investigations Can the client manage ADL's (Activities of Daily Living)? Do they need additional support?	
Carer/Family issues or needs For example: has a Needs Assessment Tool for Carers (NAT-C) been completed?	
Other For example: general issues, housing issues, financial issues	

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Summary - Home Care (continued)

Agreed Action Plan

Goal	Actions	Key Person(s) Responsible	Description

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Summary - Home Care (continued)

Time completed:

General Practitioner: _____

Tick appropriate box

- ☐ Original placed in the client's clinical notes
- ☐ Copy provided to all participants
- ☐ Copy sent to GP
- ☐ Client's care plan and assessment reviewed and updated

Palliative Care Case Conference Facilitator

Name: _____ **Position:** _____

Signature: _____ **Date (dd/mm/yy):** _____