

Palliative Care Case Conference

Organisation: _____

Summary - Residential Care

Full name of client: _____

DOB (dd/mm/yy): _____

Purpose of Case Conference: _____

Resident 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: _____

Resident 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 - Residential Care (continued)

Start time: _____

Need (as appropriate): _____

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

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Summary - Residential Care (continued)

Agreed Action Plan

Goal	Actions	Key Person(s) Responsible	Description

Palliative Care Case Conference

Summary - Residential Care (continued)

Time completed:

General Practitioner: _____

Tick appropriate box

Original placed in the resident's clinical notes

Copy provided to all participants

Copy sent to GP

Resident's care plan and assessment reviewed and updated

Palliative Care Case Conference Facilitator

Name: _____ Position: _____

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