# Palliative Care

**Case Conference**

## Summary - Residential Care

Organisation:

Enter text here.

Full name of client: Enter text here. DOB (dd/mm/yy): Click to enter a date. Purpose of Case Conference: Enter text here.

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: Click to enter a date.

Dial-in telephone number: Enter text here. Code: Enter text here.

**Resident in attendance?** **Yes**  **No**

**If no, give reason**: Enter text.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Family Members** | | | | | | |
| **Name** | **Relationship** | **Attending in person (P) or teleconference (T)** | | | | |
| Enter Text here. | Enter text here. |  | **P** |  | **T** |
| Enter text here. | Enter text here. |  | **P** |  | **T** |
| Enter text here. | Enter text here. |  | **P** |  | **T** |
| Enter text here. | Enter text here. |  | **P** |  | **T** |
| **Health and Care Professionals** | | | | | | |
| **Name** | **Discipline/Position** | **Attending in person (P) or teleconference (T)** | | | | |
| Enter text here. | Enter text here. |  | **P** |  | **T** |
| Enter text here. | Enter text here. |  | **P** |  | **T** |
| Enter text here. | Enter text here. |  | **P** |  | **T** |
| Enter text here. | Enter text here. |  | **P** |  | **T** |

Start time: Enter text here.

Need (as appropriate): Enter text here.

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

Agreed Action Plan

|  |  |  |  |
| --- | --- | --- | --- |
| **Goal** | **Actions** | **Key Person(s) Responsible** | **Description** |
| Enter text here. | Enter text here. | Enter text here. | Enter text here. |
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| Enter text here. | Enter text here. | Enter text here. | Enter text here. |

Time completed: Enter text here.

General Practitioner: Enter text here.

Tick appropriate box

Original placed in the resident’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: Enter text here.

Signature:

Position: Enter text here.

Date (dd/mm/yy): Click to enter a date.