

Planning checklist: Support at home

Organisation: _____

Palliative care case conference

Full name of client: _____ DOB (dd/mm/yy): _____

Date of case conference (dd/mm/yy): _____ Time: _____

Venue: _____ Room booked: _____

Dial-in telephone number /
online link: _____ Code: _____

Case conference facilitator: _____

Goals of case conference:

*Medicare item codes are claimable where the GP facilitates the meeting.

Name of Care Partner: _____

Family participants

| Name | Role/relationship | Contact details |
|------|-------------------|-----------------|
| | | |
| | | |
| | | |
| | | |

Health and Care Professionals

| Name | Role/relationship | Contact details |
|------|-------------------|-----------------|
| | | |
| | | |
| | | |
| | | |

| Document (tick as appropriate) | Sent | Accepted/declined | N/A |
|--------------------------------|------|-------------------|-----|
| Client & family information | | A D | |
| Client & family confirmation | | A D | |
| GP invitation | | A D | |
| GP confirmation | | A D | |

| | Needed | Obtained | N/A |
|---|--------|----------|-----|
| Clinical summary (including most recent medication chart) | | | |
| Advance care planning document (legal or non-legal) | | | |
| Carer document e.g. NAT-C needs assessment form | | | |
| Other (specify) | | | |