# 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.