Summary: Support at home

Organisation:

Palliative care case conference

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

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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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Agreed action plan

Goal	Actions	Key person(s) responsible	Description

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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):** _____