

PALLIATIVE CARE FORM

Resident Name _____ Room Number _____

The information provided on this form is to assist in documenting palliative care and services necessary for this resident. The care and services the resident receives should continue to meet standards of practice for nursing services, dietary services, social services, and any other care or services necessary for the resident to be in a safe and comfortable environment.

DIAGNOSIS: _____

The attending physician should identify those areas where the resident's response to the disease process or the end-of-life process **may be unavoidable** for the resident. Choose only if appropriate.

_____ **Weight loss** is expected with this resident. The facility/agency will, consistent with palliative care, plan and implement measures that will diminish this weight loss as much as possible.

_____ **Skin breakdown and/or pressure sores** are expected with this resident. The facility/agency will, consistent with palliative care, plan and implement measures that will preserve as much skin integrity as possible.

_____ **Dehydration** is expected with this resident. The facility/agency will, consistent with palliative care, plan and implement measures to diminish the extent of dehydration experienced by this resident.

_____ **Placement of an indwelling catheter** may be necessary for the comfort and well-being of this resident. The facility/agency will plan and implement measures to ensure the comfort of this resident with an indwelling catheter and to minimize urinary tract infections.

_____ **Fecal impactions** are expected with this resident. The facility/agency will plan and implement measures to minimize the development of impactions and/or diminish the discomfort experienced by the resident.

_____ **Gradual or rapid loss of the ability to move** about independently and/or become bedfast is expected with this resident. The facility/agency will plan and implement measures to maintain the activity level of this resident for as long as possible.

_____ This resident will require the frequent use of **narcotic/anti-anxiety/hypnotic** medications. The facility/agency will plan and implement measures to maintain the appropriate levels of medication for this resident to ensure comfort.

_____ **OTHER:** **EXPLAIN** _____

Requesting Resident/Family Signature

DATE

Attending Physician Signature

DATE

PALLIATIVE CARE FORM Instructions:

This form is to be used by the attending physician to document expected outcomes on any resident in a nursing facility (NF), who has been assessed and determined to be in need of End-of-Life care. The care and services provided by the nursing facility and/or hospice agency must be clearly identified in the comprehensive care plan developed by the nursing facility and/or hospice agency according to regulations. When a hospice agency is involved, the nursing facility and the hospice agency must work together to develop a coordinated care plan. They must specify the tasks each will do to provide the care and services the resident needs. Both entities have a responsibility to ensure that the care and services provided meet the needs of the resident that have been identified through assessment. The election of hospice by a resident does not relieve the nursing facility of care responsibilities for this resident. Individuals who could benefit from hospice have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course. Most (96.7%) of those residents die at the end of their hospice enrollment. Due to the debilitating nature of end-stage disease processes, residents frequently experience negative outcomes. These negative outcomes may include significant weight loss and/or severe pressure sores. These negative outcomes usually are unavoidable related to the nutritional status of the resident or the natural sequences that occur during the dying process.