St. Joseph Hospital Palliative Care
Data Collection Tool

Medical Record #:

Patient First Name:	**Patient Last Name:**	**Age:**	**Sex (choose one):** θ Female θ Male

Race/Ethnicity (choose one): θ Arabic/Middle Eastern θ Asian/Pacific Islander θ Black/African American θ Hispanic θ White/Caucasian θ Other or Unknown

Re-Admit? θ Yes	**# of Previous Admissions within the past year?**	**Admit Date:**	**Admit Unit:**
Admit From (choose one): θ Home θ Hospital θ SNF	**Admit via ED?** θ Yes	**Referring Physician:**	**Referring Physician Specialty:**

Primary Care Physician (PCP):

PCP Medical Group (choose one): θ St. Joseph Heritage θ St. Joseph Hospital Affiliated Physician

Payer (choose one): θ Capitated θ HMO θ MediCal only θ Medicare HMO θ Medicare only θ Medicare w/ MediCal θ Medicare w/ Private Ins θ PPO θ Private Insurance only θ SSI θ Other θ No Coverage

Admit Diagnosis/Chief Complaint:

Primary Morbid Disease (choose one): θ Cancer θ Disability Unspecified θ Heart/PVD θ Neuro θ Psychiatric θ Pulmonary θ Renal θ Other

Explain Other:

Admit for "Comfort Care" with terminal disease? θ Yes

Multiple Symptoms? θ Yes

Clinical Condition (choose one): θ Cardiovascular θ Central Nervous System θ Endocrine θ Female Reproductive θ Gastrointestinal θ Integumentary θ Lymphatic θ Male Reproductive θ Muscular θ Renal θ Respiratory θ Skeletal

Clinical Condition Type (choose one): θ Neoplastic θ Non-neoplastic

Co-Morbidities: θ Diabetes θ Infection θ Neuro Def θ Psychiatric θ Renal Failure θ Sepsis θ Substance Abuse θ Other

Explain Other:

Palliative Care Consult Date:

Primary Reason for Consult (choose one): θ Goal Clarification θ Pain Management θ Patient/Family Request θ Physician Order θ Symptom Management

Secondary Reason for Consult (choose one): θ Goal Clarification θ Pain Management θ Patient/Family Request θ Physician Order θ Symptom Management

Is this patient terminal? θ Yes

Did patient have DPAHC on admission?	θ Yes
If not, was DPAHC completed during admission?	θ Yes
If DPAHC, content require to suspend aggressive treatment?	θ Yes
If DPAHC, did MD/staff attend to content (documentation, orders)?	θ Yes
Was patient DNAR or Comfort Care prior to death?	θ Yes
If not, was patient changed to DNAR prior to death?	θ Yes
Discussion regarding prognosis/options with patient/family documented?	θ Yes
If DNAR, was form filled out completely/correctly?	θ Yes
If changed to DNAR during admit, what date first mentioned?	_____
If changed to DNAR during admit, what date first ordered?	_____

Initial Symptom Scores:

Acceptable Pain Level _____
Pain Level_____
Agitation_____
Anxiety_____
Appetite _____
Cachexia_____
Coma _____
Constipation _____
Delirium _____
Diarrhea _____
Drowsiness _____
Dyspnea/SOB_____
Fatigue _____
Inactivity_____
Nausea _____
Vomiting_____
Well Being _____

If DNAR, was resuscitation attempt made at time of death? θ Yes Overall, did it appear that we followed patient's wishes? θ Yes		Depression _____ Performance Status_____ Not Obtainable θ

Services Provided:

θ Dietitian Assessment
θ Education of Patient/Family
θ Ethics Team Consult
θ Family Conference
θ Hospice Consult
θ Pain Management
θ Psychiatric Assessment
θ Rehab Assessment
θ Risk Management
θ Social Worker Assessment
θ Spiritual/Pastoral Care Assessment
θ Symptom Management

Hospice Referral Date:

Hospice Previous to Admission?
θ Yes

Admit to Critical Care?
θ Yes

Date Admitted to Critical Care:

If transferred to ICU, on what date was patient transferred?

Date Transferred out of Critical Care:

Unit Transferred to:

Did the patient meet ICU level of care criteria for transfer?
θ Yes

If not in ICU, did the patient transfer to ICU prior to death?
θ Yes

Patient Goals of Care:

	Goals Met?	
Achievement of family milestones	θ Yes	θ No
Attend important family event	θ Yes	θ No
Comprehensive comfort measures	θ Yes	θ No
Control of pain	θ Yes	θ No
Control of symptoms other than pain	θ Yes	θ No
Discharge home	θ Yes	θ No
Discharge other than home	θ Yes	θ No
Improvement in energy level	θ Yes	θ No
Reduce burden to family	θ Yes	θ No
Resume recreational activities	θ Yes	θ No
Return to pre-hospitalization function	θ Yes	θ No

Treatment Plans:

Antibiotics	θ Yes	Anti-Inflammatory	θ Yes	DNAR	θ Yes	Psychiatric Eval	θ Yes
Anti-Convulsant	θ Yes	Anti-Psychotic	θ Yes	DPAHC	θ Yes	Sedative/Hypnotic	θ Yes
Antidepressants	θ Yes	Anxiolytic	θ Yes	Goal Setting	θ Yes	Stimulant	θ Yes
Antiemetics	θ Yes	Barbiturates	θ Yes	Octreotide	θ Yes	TPN	θ Yes
		Bowel Regimen	θ Yes	Opoids	θ Yes		

Was the patient able to communicate directly?
θ Yes

Did family vocalize concerns about comfort or treatment?
θ Yes

Was it clear which physician was directing palliative care?
θ Yes

Number of attending Physician visits in the last 24 hours prior to death?

Was there evidence of communication issues/delays between care team (RN:MD; MD:MD, family, other) during the last 24 hours prior to death?
θ Yes

Discharge Symptom Scores:

Acceptable Pain Level _____
Pain Level _____
Agitation _____
Anxiety _____
Appetite _____
Cachexia _____
Coma _____
Constipation _____
Delirium _____
Diarrhea _____
Drowsiness _____
Dyspnea/SOB _____
Fatigue _____
Inactivity _____
Nausea _____
Vomiting _____
Well Being _____
Depression _____
Performance Status _____
Not Obtainable θ

Last Pain Score if Expired:

Expired Pain Score Four or Less?
θ Yes

Discharge Date:

Discharge Disposition (choose one):
θ Expired
θ Home
θ Home with Home Health
θ Home with Hospice SNF
θ Hospice
θ Rehab Hospital
θ SNF with Hospice

Place of Death (choose one):
θ Critical Care
θ General Unit
θ Home
θ SNF
θ Not Applicable

Is place of death the patient's preferred site of death?
θ Yes

Bereavement Care Plan?
θ Yes

Number of times this patient was transferred across care settings in the last three months of life?

Comments: