

Directions

Shade circles like this: ●

Do not shade like this: ⊗ ⊙**Outpatient PCT Data Collection Tool****ID**

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Date of Birth: (mm/dd/yyyy)

		/			/				
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County of Residence:

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Gender:

- M
 F

Pediatric Service:

- Yes

Ethnicity:

- Black or African American
 White or Caucasian
 Asian or Pacific Islander
 American Indian/Alaskan Native
 Hispanic or Spanish
 Other _____

Marital Status:

- Single
 Married
 Divorced
 Separated
 Widowed

Date seen:

		/			/				
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Patient was seen in:

- Office: (Specify) _____
 Home _____
 Nursing Home/SNF
 Personal Care Home
 Assisted Living Facility
 Other: (Specify) _____

INITIAL Reason for Consult: (Mark only one.)

- Goal clarification Pain and symptom management
 Psych/spiritual support of pt/family Caregiver Fatigue

Primary Diagnosis for Consult:

- Cancer Dementia
 Cardiac General Disability
 AIDS Sepsis
 Kidney Multi-Organ Failure
 Pulmonary Heart Defects
 Liver Genetic Anomalies
 Neurologic Drug Addiction
 Noncardiac Vascular Trauma

Did the patient have multiple chronic illnesses?

- Yes No

↳ If yes,

- ≤ 2 > 2

PPS at first contact:

				%
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Would you be surprised if the patient died in the next year?

- Yes No

Did patient have decision making capacity at time of first visit?

- Yes No Unable to determine

Does family/support person display signs of inappropriate coping or anticipatory grief?

- Yes No Unable to determine

Symptoms at initial assessment: (Mark all that apply.) Note: The symptoms are determined by the patient's self-report or by observation.

- | | |
|---|--|
| <input type="radio"/> Anorexia | <input type="radio"/> Dyspnea |
| <input type="radio"/> Anxiety | <input type="radio"/> Fatigue |
| <input type="radio"/> Confusion related to dementia | <input type="radio"/> Insomnia |
| <input type="radio"/> Constipation | <input type="radio"/> Nausea |
| <input type="radio"/> Cough | <input type="radio"/> Pain |
| <input type="radio"/> Delirium | <input type="radio"/> Best sleep |
| <input type="radio"/> Depression | <input type="radio"/> Well-being |
| <input type="radio"/> Drowsiness | <input type="radio"/> No symptoms |
| <input type="radio"/> Dysphagia | <input type="radio"/> No symptoms due to decreased LOC |



Pain Assessment Scale Used:

- Numerical Rating Scale PAINAD Scale PIPS (Premature Infants) NIPS (0-2 years) FLACC Scale (2 months-7 years)

Pain Assessment: Date : / /

On a scale of 0 to 10, where 0 equals no pain and 10 equals the worst pain you can imagine, what level is your pain right now?

- 0 1 2 3 4 5 6 7 8 9 10

Pain Assessment: Date : / /

On a scale of 0 to 10, where 0 equals no pain and 10 equals the worst pain you can imagine, what level is your pain right now?

- 0 1 2 3 4 5 6 7 8 9 10

Pain Assessment: Date : / /

On a scale of 0 to 10, where 0 equals no pain and 10 equals the worst pain you can imagine, what level is your pain right now?

- 0 1 2 3 4 5 6 7 8 9 10

DNR: Was DNR discussed during this visit?

- Yes No

DNR Card: Was DNR Card initiated by Palliative Care?

- Yes No

Living Will

- Discussed Completed

MPOA

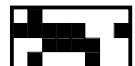
- Discussed Completed

HCS

- Discussed Completed

POST Form

- Discussed Completed



Treatments in use and changes in Patient Care:

"In Use" should be selected regardless of when the treatment was started, either prior to or during visit. If a treatment is stopped or avoided, fill in the respective circle.

<u>In Use</u>	<u>Stopped</u>	<u>Avoided</u>
<u>Yes</u>		
<input checked="" type="radio"/> Intravenous fluids	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Intravenous Antibiotics	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> TPN/PPN	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Gastric feedings	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Dialysis	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Diagnostic labs	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Diagnostic x-rays	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Mechanical ventilation	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> BIPAP OR CPAP	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Transfusions	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Chemotherapy	<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/> Radiation Therapy	<input type="radio"/>	<input type="radio"/>

Interventions by PCT: (Mark all that apply.)

- Education about the process of their disease, prognosis and options for care.
- Conduct a patient and family care conference with appropriate members of the interdisciplinary team.
- Education about benefits and burdens of specific treatments or potential interventions.
- Provide information about spiritual care, social work or counseling services available.
- Provide individualized education and support to families and unlicensed caregivers in a timely, culturally appropriate manner.
- Provide pain and symptom management recommendations.
- Education about the signs and symptoms of imminent death or dying process in a timely, culturally appropriate manner.
- Hospice option for care was presented at this admission.
- Hospice referral provided.

Outcomes or decisions followed by family: (Mark all that apply.)

- Referral for social support
- Referral for spiritual support

