PALLIATIVE CARE CONFERENCE SUMMARY

Name of Resident: _____ Date of Birth: _____/____/____
(DD/MM/YYYY)

Purpose of Palliative Plan of Care Conference:

Participants:

Resident in attendance? ☐ YES ☐ No

Note: If resident is mentally capable for own personal decisions, resident must be present for palliative care conference to take place. Others attending are only included if resident gives permission.

Resident's future or acting legal decision maker in attendance? ☐ YES ☐ No

Health Care Providers & Family Members
(Family Members may attend ONLY If capable resident/incapable resident's legal decision maker agree)

Name	Discipline/Position/Relationship

Key issues Discussed & Wishes or Goals Shared
Symptoms
Social/psychological /spiritual needs
Assessments/investigations
Other (e.g., funeral home selection)

Care Planning and Treatment Plan

Treatments Consented to	Actions	Key Person(s) responsible	Review date

Time Conference Commenced: _____ Time Completed: _____

Physician's or NP's Name: _____

Check the appropriate box:

- ☐ Original placed in the resident's clinical notes
- ☐ Copy sent to Physician or NP
- ☐ Copy Offered to participating allied health professionals
- ☐ Copy offered to the resident/legal decision maker
- ☐ Resident's care plan and assessments reviewed and updated

Facilitator's Name:_____

Position: _____Signature: _____ Date: ___ /___ /_____/
(DD/MM/YYYY)