Palliative care plan

Consumer name: ____________________________________**DOB**: ________________

Address:____ **CIS No**:____________

Telephone No: _____________**Person responsible**:__________________________

Medical information

Diagnosis of illness

____

____

Date of diagnosis

____

Current medical treatment(s)

____

____

____

____

Prognosis

____

____

____

Name of treating medical officer(s)_______________________________________

Address____

Telephone____

The proposed treatment(s) and procedures

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Has the consumer been informed of their illness YES NO

If no, has the consumer been informed that they have an illness? YES NO

Planning areas

Physical

____

____

____

____

____

Emotional / psychological

Social

Family

Spiritual/ religious

Future care

Communication with others about the illness

Equipment and or additional human resources required

Does the consumer have a documented 'No CPR order'? YES NO

If yes, ensure that the order is attached to the plan.

Plan

Goal/ action	Date to implement	Priority	Person responsible

Members of planning meeting

Name	Relationship to consumer	Address	Telephone

Members unable to attend the meeting

Name	Relationship to consumer	Address	Telephone

Review meeting

Date ____

Time____

Address____

Venue____

Agreement

Signature of consumer_______________________________________Date__________

Signature of Substitute Decision Maker______________________Date________

Print Name of Substitute Decision Maker _________________________________

Relationship to consumer____

Address____