Patient Label

ED Palliative Care Screening Tool

General Information

Relation of person providing information (circle): Patient parent child sibling other: ___________________________

Patient Age: _______ Date of ED Visit:__________ Mode of Arrival: Car EMS Bus Private ALS other_________

Arrived from: home nursing home another hospital specialty hospital shelter other: ___________________

Key Caregiver(s): Who helps take care of you/patient or do you take care of yourself? Self Someone else

Name: _____________________________ Relation: ___________________________ Phone: ________________________

What physician is taking care of most of your medical problems (Primary care and/or specialists)

__________________________________ _____ __ ____

Do you make your own health care decisions? Yes No

If you were unable to make healthcare decisions, who would you select to make those choices?
Name: ________________________ Relation: ___________________________ Phone: ________________________

Do you have any advanced directives such as a Living Will, Do Not Resuscitate or Allow Natural Death orders:? Yes No
If yes, which ones: (circle all that apply): Living Will Do Not Resuscitate Natural Death

Language Is English your primary language?: Yes No If no, what is your primary language? _________________

REALM-R Unable to complete______ Unable to speak < 6 words_______ Realm-R Score__________

Disease State: Do you or the person you are caring for/represent have one or more of the following advanced illnesses or symptoms:

Chronic Obstructive Pulmonary Disease (COPD) or other chronic lung disease? Y N	Oxygen dependent Y N	SOB at rest Y N	Bed bound more than 3 months? Y N Wt loss despite tube feedings? Y N Unable to care for self? Y N
Congestive Heart Failure (CHF) or other chronic heart disease? Y N	Oxygen dependent Y N	SOB at rest Y N	Bed bound more than 3 months? Y N Wt loss despite tube feedings? Y N Unable to care for self? Y N
Dementia, stroke, failure to thrive or Alzheimer's disease? Y N	Oxygen dependent Y N	SOB at rest Y N	Bed bound more than 3 months? Y N Wt loss despite tube feedings? Y N Unable to care for self? Y N
Cancer? Y N Metastatic, recurrent ? Y N	Oxygen dependent Y N	SOB at rest Y N	No further curative treatment? Y N Bed bound more than 3 months? Y N Wt loss despite tube feedings? Y N Unable to care for self? Y N
Kidney Failure Y N Liver Failure? Y N	Oxygen dependent Y N	SOB at rest Y N	Bed bound more than 3 months? Y N Wt loss despite tube feedings? Y N Unable to care for self? Y N
Other conditions such as HIV or AIDS, Parkinson's or ALS? Other:_________________	Oxygen dependent Y N	SOB at rest Y N	Bed bound more than 3 months? Y N Wt loss despite tube feedings? Y N Unable to care for self? Y N

a. Have you ever been told you have a limited time to live because of your disease? Y N
b. Have you had more than one ED visit in the last 3 months related to your disease(s)? Y N
c. Have you had 2 or more hospital admissions for your disease in the last 6 months? Y N
d. Have you had admission(s) to an ICU for your disease in the last 6 months? Y N

Is your ED visit today because of (related to): Check all that apply:

Difficult to control physical symptoms (nausea, shortness of breath, fatigue, etc.)		Difficult to manage or increasing emotional symptoms	
Uncontrolled pain		Feeding problems or weight loss	
Caregiver burnout or unavailable		Need for medications	
Need for equipment			

Functionality/Performance

Grade	ECOG
0	Fully active, able to carry on all pre-disease performance without restriction
1	Restricted in physically strenuous activity but ambulatory and able to carry out work of a light or sedentary nature, e.g., light house work, office work
2	Ambulatory and capable of all self-care but unable to carry out any work activities. Up and about more than 50% of waking hours
3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair

Nutrition Is your oral intake: normal reduced sips none feeding tube

Pain and Symptom Assessment Circle the number that best describes your symptoms during the past week:

Pain	0 1 2 3 4 5 6 7 8 9 10 Worst possible pain
Tiredness	0 1 2 3 4 5 6 7 8 9 10 Worst possible tiredness
Anxiety or worry	0 1 2 3 4 5 6 7 8 9 10 Worst possible anxiety
Nausea	0 1 2 3 4 5 6 7 8 9 10 Worst possible nausea
Weakness	0 1 2 3 4 5 6 7 8 9 10 Worst possible weakness
Drowsiness	0 1 2 3 4 5 6 7 8 9 10 Worst possible drowsiness
Distress	0 1 2 3 4 5 6 7 8 9 10 Worst distress
Shortness of breath	0 1 2 3 4 5 6 7 8 9 10 Worst possible shortness of breath

Comments and Notes

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