PalliativeCare Center
Consulting & Education

Phone: 304-941-1951 Fax 304-941-1918

PALLIATIVE CARE CONSULT FORM

Patient Name:_____ DOB_____

Attending Physician:_____ Date:_____

Consult requested by:_____

Orders
Palliative Care Consult for: ___ Goal Clarification _____ ___ Pain Assessment/Evaluation _____ ___ Symptom Assessment: _____ Anxiety _____ Depression _____ Insomnia _____ Restlessness _____ Dyspnea _____ Other_____
This is a Consult service. After a thorough assessment, we make recommendations for your review.
Physician Signature_____