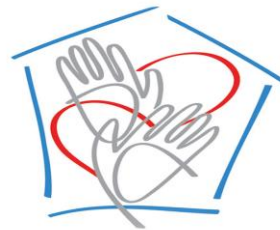


PalliativeCare Center

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 _____