Approach to a Palliative Care Consult / Admission

Patient Profile and Reason for Consult/Admission

Sex, age and present diagnosis (e.g. 56yo woman with lung cancer metastatic to brain, liver and lungs admitted from home for symptom management and possible end of life care)

Illness Course (HPI)

- Date of diagnosis
- Treatments (chemo, radiation, surgery)
- Dates of recurrence / disease progression
- Any complications secondary to cancer, such as effusions, emboli, DVT, infections, fistulae
- Recent changes in symptoms, functioning

Assessment - *Crucial part of consult*

1. **Physical & Emotional Symptoms**

   Assess physical symptoms the patient is experiencing. Use the symptoms on the ESAS as a guide, either asking the patient to complete the form or going through each symptom verbally. Include depression/mood and anxiety. Remember to ask the patient if they are having any other symptoms that may not be on the list.

   For any symptom rated 4 or more, or of concern, assess more completely than just the numerical/verbal scale. Characterize the nature of the symptom, timing, aggravating and relieving factors, effect on functioning, treatments that have been tried and whether they were effective.

2. **Physical exam**

   Must be tailored to the patient and to the phase of their disease.

   In clinic and for consults, limit examination to areas relevant to symptoms the patient is experiencing. For admissions to 16P, a screening physical examination is generally appropriate.

   Remember to include an overall impression – body habitus, affect, alertness, presence/absence of confusion, functional status (eg transferring, walking) if witnessed.

3. **Social**

   Ask about the patient's living situation (house/apt, who lives with the patient), family and close friend supports, current or past occupation, extended health coverage, smoking, alcohol and recreational drug use, and amount of help required at home. These can all influence treatment, supports provided and planning for the future.

4. **Spiritual** – this does NOT = religion, but may include religion. Common questions include asking about how they are coping with their illness and finding meaning in their lives.

Past Medical History - List all relevant past medical and surgical conditions.

Medications - Include all current medications. For those relevant to symptom management, include whether or not the patient feels that they are working and if not, what they have used in the past

Investigations - Include relevant findings from recent imaging and bloodwork.

Goals of Care What are the patient and/or family hoping that the consult/admission will accomplish
What is their focus? (Curative treatment, Pain/symptom management, Quality of Life, etc)
Topics that often surface include DNR, hydration, artificial feeding, prognosis

Palliative Performance Scale (PPS) - Include in order to document functional status & track change over time.

Disposition

Often can't be fully determined at the time of admission or consult, but documentation of expectations of the patient/family, &/or your own impression. This is relevant to consulting OT/PT, SW, and CCAC.
Options are: Home, End-of-Life at PMH (if prognosis in days to 1-2 weeks), home, PCU or Hospice outside of PMH, or rarely alternate facility eg Long-term care, Rehabilitation.

Summary and Recommendations/Plan

Unless instructed otherwise, review the case with the staff physician before formalizing recommendations with the patient or on the chart, but do your best formulate suggestions for discussion.