QUEEN’S PALLIATIVE MEDICINE BLOCK ORIENTATION

Welcome to the Queen’s Palliative Medicine Team! Our inter-professional team provides outpatient, acute inpatient, and end-of-life palliative care at Kingston Health Sciences Centre/Kingston General Hospital (KHSC/KGH), Cancer Centre of Southeastern Ontario (CCSEO), Providence Care Hospital (PCH) and the Kingston community (Comm). Over the next four weeks rotating residents/fellows/clerks will be involved in palliative care consultations, ongoing follow-ups and on-call services.

You have been assigned to one of the two following streams for the duration of your 4-week rotation:

1. **KGH/CCSEO Stream** – Acute (KGH) inpatient care for both our own complex palliative care beds and as consultants for patients under the care of other specialties (i.e. Medicine, Oncology, Surgery, etc.) and outpatient Palliative Care clinics at CCSEO.

2. **PCH/Comm Stream** – Palliative Care Unit (PCU) is a 10-bed service located at PCH (Heritage 2) for end-of-life care for palliative care patients and community palliative care provides new consultations and ongoing follow-up for palliative care patients in the home.

**PALLIATIVE CARE TEAM MEMBERS**

- **KGH/CCSEO Physicians**: Dr. Majid Iqbal, Dr. Jean Matthews, Dr. Danielle Kain, Dr. Leonie Herx, Dr. Craig Goldie, Dr. Anna Voeuk, Dr. Andy Selbie and Dr. Hasitha Welihinda are the primary staff physicians. Dr. Hasitha Welihinda is a Nephrologist who provides part-time palliative care.

- **PCH/Comm Physicians**: Dr. Juliane Bagg, Dr. Anna Voeuk, Dr. Andy Selbie, Dr. Chris Frank and Dr. Leonie Herx provide care at the PCU and community palliative care.

- **Administrative Staff**: Ruili Fang is the Program Assistant and the main contact for rotation-related issues. Jess Serson is the Palliative Medicine Administrative Assistant who manages the clinical work and provides the patient lists for residents on rotation. She is also assisting for all patients followed at home.

- **Clinical Nurse Specialist**: Nancy Brown is part of the KGH consult team and regularly follows patients on our inpatient list alongside the residents/fellows. She has expertise in CADDs and disposition supports.

- **Nurse Navigator(s)**: Melissa Touw is the nurse navigator for the community patients, and Jennifer Stinson is the nurse navigator for the CCSEO patients.

- **Interprofessional Team**: Nursing, Spiritual Care, Social Workers, Dieticians, PT, OT, and Volunteers.

**SCHEDULES/LISTS**

- **Weekly Schedules** are sent out on Fridays for the coming week by Ruili to all residents, staff and physicians regarding academic/clinical rounds, teaching sessions, and clinical assignments (residents and staff). Please notify Ruili ASAP if there are any issues with the schedule.

- **On-Call Schedules** are sent out before the block, as well as on weekly and monthly rotation schedules sent out by Ruili. Residents are listed by last name with a staff physician for the days that they are on-call.

- **Resident Presentations Schedules** are sent out by Ruili during the rotation. All rotating residents are expected to present (informally, no PowerPoint) a 5-10 minute presentation using one of the pre-selected palliative care topics: Pain; Nausea/Vomiting; Dyspnea; Constipation; GOC/ACP; Delirium. Email Ruili
which topic you have picked and it will be first-come-first-served so whoever calls dibs on a topic first will get it.

- **Patient Lists** The day before your first day of rotation, Ruili will send you a “patient lists” email which contains the links (sharepoint) of patient lists: KGH list, PCU list and Community list.

## ROUNDS/MEETINGS

- **Orientation (the first Tuesday of the block) and Resident Seminars (Tuesdays)** are held at 34 Barrie St at 8am. Residents/fellows receive teaching on CADD pumps, and review a palliative care quiz, found at: [https://meds.queensu.ca/source/rotation_in_pc_trainee_knowledge_test%20(1).pdf](https://meds.queensu.ca/source/rotation_in_pc_trainee_knowledge_test%20(1).pdf).
- **Medical Mortality and Morbidity Rounds (ALL RESIDENTS)** are held most Wednesday mornings at 8:00AM in Etherington Auditorium. Residents in the PCH/Comm Stream can view the rounds at PCH (Lakeview Wing – Level 1; Small Conference Room). *(Currently delivered on Zoom due to COVID 19.)*
- **Interdisciplinary Team Rounds (KGH Residents only)** are held on **Wednesday at 9:15AM in the KIDD 10 Conf Room** for multidisciplinary review of our inpatient list.
- **Medicine Grand Rounds (7:45AM; Etherington Auditorium) OR Oncology Grand Rounds (8:00AM; Botterell Hall Rm B143)** are Thursday mornings; either can be attended. *(Currently delivered on Zoom due to COVID 19.)*
- **PCU Interprofessional Rounds (PCU/Comm Residents only)** are held Thursdays at 845AM at the PCU (Heritage Wing – Level 2; Conference Room) to discuss multi-disciplinary care needs for the patients.
- **Resident Journal Club OR Palliative Grand Rounds OR Reflection Rounds (ALL RESIDENTS)** are typically held one Friday per 4-week block (most blocks) at 8:00AM. Location is usually listed on your schedules with email reminders sent out before the event.

## KGH/CCSEO STREAM – Consult Service

- **Patient “Short” Lists** handed out each morning and reviewed by the team. This meeting typically occurs just after morning rounds/meetings at either 34 Barrie Street or on Kidd 9.
- **Rounding** - After the list is reviewed and residents/fellows are assigned patients, the team disperses to round on our patients. Residents stay in contact with the team primarily through a WhatsApp Group.
- **Progress Notes** – Each patient you see/review should have a dated progress note (titled “Palliative Care”) written on them by the resident. Please document the time during which the patient was seen (i.e. 0940-1005) and ensure a detailed and legible note including plan/changes/suggestions.
- **Orders vs. Suggest Orders:**
  - For patients under Palliative Medicine (bold on short list, usually on Kidd 9): we write progress notes and ORDERS (on GREEN order sheets) and review/co-sign any suggest orders on these patients.
  - For consult patients: write progress notes and SUGGEST ORDERS (on GREEN order sheets; usually write “Palliative Care suggests”). The MRP service will then accept/reject those suggestions.
- **Running the list** – after you have seen your own patients, the team will meet (usually around 12:30pm on Kidd 9). We go over issues for the day, review new consults and coordinate follow-up plans.
- **Consults** – can come up at any point in the day, usually from other inpatient teams or emergency department. A resident (typically a fellow) will carry the consult pager and assign a resident to see the new consult. Our consults are written on YELLOW Consult Sheets, which should be already in the patient’s chart. Residents are to complete their history on the back of that yellow sheet, leaving the front for the Staff Physician’s note. We would also write SUGGEST ORDERS, should we need to. We also **DICTATE** our consults (Inpatient Consultation code: 04; please press ‘6’ before submitting dictation for STAT).
- A template for inpatient consult dictations is included at the end of this document.
• Admission Notes – are written for patients that are directly admitted to our inpatient beds from ER, clinic, or home. Admission histories are written on WHITE History and Physical Examination Sheets. We would write ORDERS for these patients under our care, either via EntryPoint or on a GREEN order sheet.

KGH/CCSEO STREAM – Clinic

• Clinic is run out of CCSEO – Burr Wing, Level 1, Clinic A from 8:45AM to 4:30PM.
• Clinic schedules consist of new consultations and follow-up visits. Nurses at the clinic typically see patient’s first for an initial assessment: vital signs, weight, medication reconciliation and initial review of symptoms based on ESAS (completed by patients each visit electronically when checking in). The nurse would then review the assessment with you prior to seeing the patient.
• New consults – usually 2 are scheduled in the mornings. New consults are typically referred by Oncology to assist with pain and symptom management and/or goals of care discussions. We undertake complete palliative history and physical exam. You can review notes from oncology and other teams in PCS.
• Follow-up Visits – are spread throughout the day. You can review previous visits and interim history on PCS. Typically, follow-up visits are much shorter than consultations and focused on previously discussed symptom issues and/or new issues that have occurred since last visit. Visits are reviewed with the clinic staff physician prior to the patient leaving. Prescriptions will be written and faxed to the patient’s pharmacy and other referrals may be arranged.
• If needed, patients can have bloodwork, ECGs, IV hydration as well as oral/parenteral medication for symptom management in clinic. Orders and diagnostic tests are entered in EntryPoint.
• If a patient requires admission to hospital, we determine whether appropriate to be under palliative care or Medicine. For the former, we advise the inpatient team and they will send a resident to do the admission paperwork. For the latter, we consult GIM (attending to attending) to see the patient in clinic.
• All clinic visits are dictated via Enterprise phone dictation system. Details on how to dictate are posted in clinic, and you can review how to formulate your dictation with the staff and look at the template.
  o Dictation phone line: 6900
  o Your PCS login ID (5-digit code) = dictation code and password
  o Consultation code: 31 | Follow-up visit code “Treatment Letter”: 33
• IT IS HIGHLY RECOMMENDED that residents review charts for clinic consults before coming to clinic to ensure that clinic runs in a timely manner. Clinic schedules can be viewed via PCS by clicking the arrow next to the “Main Desktop” icon >>> “KGH/HDH Patient Processing” >>> “Patient List – Clinic”; and then searching the schedule under the appropriate physician’s name and clinic date.

PCH/Comm STREAM – Palliative Care Unit

• Residents start their days at PCU (after rounds/meetings) and typically spend the morning seeing some of the 10 end-of-life patients and reviewing with staff.
• Though PCH uses a similar system to KGH (i.e. PCS), there is a separate training session for their EMR (called “ePR”), usually held the first morning of your rotation. Information on this training session and login credentials is emailed to you prior to your rotation and login will be activated at the orientation.
• All documentation at PCH is electronic, and the paper charts typically only contain patient demographic and admission information.
• Daily visits with patients are documented under progress notes, through ePR.
• Orders are entered via the “PC Order Entry” tab on ePR. If you are struggling with it, ask an attending.
• New Admissions occur on a regular basis and can come from patients our team follows in the community/KGH or referred by other physicians in the community. New Admissions are also documented electronically and include: an admission note, goals of care documentation, and medication reconciliation. Typically, the patients you admit are the ones you follow on a day-to-day basis.
• **Patient lists** can be viewed on ePR, and patients at the PCU are typically divided amongst the two residents that are assigned to PCH/Comm. Once patients are all seen, they are then reviewed with your attending and progress notes/orders are entered into ePR.

• Afternoons usually consist of community home visits/consults (details on next page) with attending doctors, unless it is your turn to do a new admission to the PCU.

**PCH/Comm STREAM – Community (Home) Visits**

• **New consults** in the community are seen on a regular basis. For patients you see at home, you will perform a complete history and physical exam under the supervision of one of the community staff physicians. Together, you will come up with a treatment and ongoing follow-up plan (if the patient is appropriate to be followed by our community service). **Residents dictate a consultation letter (code 31).**

• **Follow up visits** are usually completed with the attending physician, but at times on your own (if comfortable). **Progress notes are dictated using code 33.**

• **Prescriptions, Home Care Nursing Orders, Symptom Response Kits, Oxygen** orders are all done via fax and/or through Home Care eReferral on PCS. Your staff physician can review this process with you in more detail.

• **Important Phone Numbers/Contacts** are listed at the end of this document.

**ON-CALL**

• **Weekday Call** – begins at 5:00PM and runs until 8:00AM the following day.

• **Weekend Call** – is generally 5:00PM Friday – 8:00AM Sunday or 8:00AM Sunday to 8:00AM Monday. You will round on both weekend days (and/or holidays) at KGH and/or PCU and see new consults; discuss details with the on-call attending prior to the weekend.

• Call is **HOME CALL. Please keep your pager on during this entire period. Pages must be answered within 10 minutes;** if you are unable, please contact your attending to discuss the situation (i.e. dealing with another critical issue).

• **Important rules to consider when on-call are:**
  o Touch base with the staff physician prior to your call shift (page/phone/text).
  o **IF YOU DON’T KNOW, PLEASE ASK** (your staff, as they are happy to help)
  o Always RECORD who is calling, the patient’s information (name, CR#, etc.), and contact information in case you need to call them back.
  o **Determine if the patient is actually followed by our team**, as we occasionally receive calls from home care nursing who may not realize that we are not MRP or may not even know the patient at all. Prior to providing medical advice, contact the attending to confirm we are following the patient if there is any uncertainty.
  o **We do not routinely offer after hours/on-call services for patients followed in palliative care clinic,** unless they are otherwise listed on our “Long” list. Please call the staff if you are uncertain if we should be providing the advice.
  o Requests for use of sedating medications or palliative sedation to manage agitation (e.g. neuroleptics such as Nozinan or benzodiazepines such as midazolam) **MUST be discussed** with the attending physician. For an agitated patient it is acceptable to order a single stat dose of sedative medication after which you should notify your attending and discuss the ongoing plan; however rapid titration or initiation of regularly scheduled sedating medications should always be discussed with the attending prior to ordering.

• **We are responsible for** answering pages from nursing regarding our **own inpatients at KGH and PCH.** At KGH the nurses will typically call the in-house “subspecialty” medicine resident who is responsible for our patients overnight first, who may call us.
- KGH pages are typically switchboard (613-548-2473) or a 4 digit extension which you can reach by calling 613-549-6666 then enter the extension.
- PCU pages will be long: 61354490082824 or 544490082824: call PCH 613-544-4900 and enter extension 82824 (Heritage 2).
- These calls typically consist of a need for nursing orders for end-of-life symptom issues. If new concerning issues do arise, you may have to attend the hospital to consider appropriate management or investigations.
- It is best to inform your staff of new issues that arise, and to discuss your plan.

- **We are responsible for our community patients**, which can be found on our “Long” lists (updated every Friday). Many calls can be from community home care nurses or directly from patients/families. These may include requests for prescription renewals (which often can be deferred until the following day) or symptom issues. If a call does come from a patient or family regarding a symptom issue, you should direct them to call their community nurse first to do an assessment and who may later page you directly through switchboard. Recent notes about ongoing care of the patient can be found on PCS under “Clinic Visits”.

- You may receive calls about patients dying at PCH or community; details below on how to manage them.

- Residents need to provide an email summary of all on-call interactions by 9:00am on the morning after call. It should be sent to the “Palliative Medicine Handover” email group from your KingstonHSC email address for security.
  - You should have received a template email to your KHSC email address from Ruili at the start of the orientation: use that as a template for your handover and edit the date and on-call attending; we suggest you save it as a “draft” and edit it during the evening/weekend so it is ready to send first thing in the morning.
  - If you did not receive any calls overnight, you must still send an email saying “No overnight calls” so everyone is aware.
  - You will still need to physically deliver any death certificates before your clinical day starts to the office at 34 Barrie St – if the door is locked you can put it through the mail slot.

### DEATH CERTIFICATES

- **Death Certificates** will typically be completed by the MRP/Resident that is following the patient, though may become your responsibility if you are on-call. Blank certificates are included in your orientation package, and it would be helpful to review their contents.

- **If a death occurs at KGH (palliative bed):**
  - The in-house (non-take) resident pronounces the patient and completes the death certificate; they do not finalize the discharge summary. They page in the morning to hand over the death. You will need to complete the discharge summary.

- **If a death occurs at PCU:**
  - Nurses will pronounce the death.
  - If it is before 10:00PM you will be paged to complete the death certificate, and can leave with the nursing station to coordinate pick-up with the funeral home.
  - If it is after 10:00PM, you may be informed (usually not) and the paper work will need to be completed in the morning.
  - In addition to the death certificate, a “Consent to Release” form will also need to be completed before a body can be transferred and the discharge paperwork must be signed: date of admission, date of discharge, and most responsible diagnosis – the rest can be blank.

- **If death occurs in the community:**
  - You will likely receive a call from nursing that the patient died and they pronounced the death (unless they do not have an order to, or in other rare circumstances). Ensure the following:
  - The patient is followed by our community team, the time and date of death, the name of the patient’s funeral home (and contact info).
Complete the Death Certificate – ensure you write the patient’s address in the “Place of Death” space. If after-hours (i.e. on-call), this must be completed by MRP/Resident before 9AM the following morning and provided to Keri to arrange pick-up, courier. On weekends, call the funeral home to determine how to get the certificate to them (may require delivery to the funeral home, or pick-up from Admitting department at KGH (even if not KGH inpatient).

- **Death Certificate Completion** – for information regarding completion of a Death Certificate, use the following link: [http://www.publications.serviceontario.ca/ecomlinks/026062.pdf](http://www.publications.serviceontario.ca/ecomlinks/026062.pdf). An example death certificate is included at the end of this document. Note: During this rotation, your address should be written as our office address: 34 Barrie Street, Kingston, ON K7L 3J7

- **In RARE Circumstances**, the coroner’s office may need to be called. We are often aware of potential coroners’ cases beforehand, such as a patient with recent surgery/procedure, accident/fall or other concerning event in the 28 days prior to death – consider calling the coroner but discuss with the staff physician before proceeding.

**OTHER IMPORTANT INFORMATION/CONTACTS**

- **Palliative Care Unit:** Heritage 2, call 613-544-4900 x 82824
- **Community Palliative Care Team (8AM – 5PM):** 613-449-3983
- **Keri Bazinet (Office Administrative Assistant):** 613-548-2485 or 613-549-6666 x2485
- **Ruili Fang (Academic/Program Assistant):** 613-549-6666 x3223
- **Medical Pharmacy:** For injectable medications (8am-8pm 7d/wk): Ph 613-384-3914 | Fax: 613-384-1905
  - SRKs and CADDs are made by this pharmacy, but prescriptions for these must be sent to LHIN directly.
- **SE LHIN Home and Community Care:** (8am-8pm 7d/wk): Ph 613-544-7090 | Fax: 613-544-1494
  - CADD, Symptom Response Kit, Injectable med orders, medications changes/orders for nurses need to be faxed here
- **Nursing Agencies:** To reach a patient’s nurse 24/7:
  - St. Elizabeth: 613-530-3400 (chart is in the home)
  - CBI: 613-384-7891 (no chart in the home)
  - Paramed: 613-549-0112 (chart is in the home)
- **Oxygen:** To get palliative oxygen started or to discuss other oxygen concerns
  - Kingston Oxygen: 613-548-7301
  - Medigas: 613-546-5529
Ontario
Ministry of Government Services
Office of the Registrar General

Medical Certificate of Death - Form 16

Hospital code number

INFORMATION ABOUT THE DECEASED

1. Name of deceased (last, first, middle) Smith, John

2. Date of death [month - by name, day, year (in full)] November 10, 2018

3. Sex (M or F) M

4. Age 85

5. If under 1 year of age: Months Days

6. If under 1 day of age: Hours Minutes

7. Gestation age

8. Birth weight

9. Place of death (name of facility or location) Kingston Health Sciences Centre (or PCH, or pt address) hospital nursing home residence other (specify)

10. City, town or village or township Kingston (or city/town where pt resided) Regional municipality, county or district Frontenac (look up if unsure)

CAUSE OF DEATH

11. Part I Immediate cause of death

(a) Metastatic Lung Cancer due to, or as a consequence of

(b) [specify cause of death]

(c) [specify cause of death]

Part II Other significant conditions contributing to the death but not causally related to the immediate cause (a) above

Chronic Obstructive Pulmonary Disease

12. If deceased was a female, did she die during pregnancy (including abortion and ectopic pregnancy) yes no

13. If deceased was a female, within 42 days of pregnancy yes no

14. Did the deceased die within 1 year of last childbirth yes no

15. Date of delivery (mm/dd/yyyy)

16. Reason for surgery and operative findings

If yes to #14, fill in operative findings

17. Autopsy being held yes no

18. Does the cause of death stated above take account of autopsy findings N/A yes no

19. May further information relating to the cause of death be available later? N/A yes no

ACIDENTAL OR VIOLENT DEATH (if applicable)

20. If accidental, suicide, homicide or undetermined (specify) yes no

21. Place of injury (e.g., home, farm, highway, etc.)

22. Date of injury (mm/dd/yyyy)

23. How did injury occur? (describe circumstances)

CERTIFICATION

By signing below, you certify that the information on this form is correct to the best of your knowledge.

24. Your signature (physician, coroner, RN/EC) other

25. Date (mm/dd/yyyy)

26. Your name (last, first, middle) Smith, John

27. Your title: Physician no other (specify)

28. Your address (street number and name, city, province, postal code) 34 Barrie Street, Kingston, ON K7L 3J7

TO BE COMPLETED BY THE DIVISION REGISTRAR

By signing below, I am satisfied that the information in this Medical certificate of death is correct and sufficient and I agree to register the death.

Signature:

Left blank

Date (mm/dd/yyyy)

Registration number

Div. reg. code no.

For the use of the Office of the Registrar General only

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Personal information contained in this form is collected under the authority of the Vital Statistics Act, R.S.O. 1990, c.v.4 and will be used to register and record the births, stillbirths, deaths, marriages, adoptions, change of names, corrections or amendments, provides certified copies, exist a, certificates, search notices, photographs and for statistical, research, record, law enforcement, adoption and education purposes. Questions about this collection should be directed to the Deputy Registrar General at PO Box 4650, Thunder Bay ON P7B 6L8. Telephone 1-800-661-2196 or 418-325-5385.

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Disponible en français
Edmonton Symptom Assessment System Revised (ESAS-r)

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<td>Best Wellbeing</td>
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<td>(Wellbeing = how you feel overall)</td>
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<td>No Best Wellbeing</td>
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<td>Other Problem (For example constipation)</td>
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<tr>
<td>No Other Problem</td>
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<td>Worst Possible Other Problem</td>
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</tbody>
</table>

Patient Name ________________________________  Completed by (Check one)

Date (yyyy-Mon-dd)  

Time (hh:mm)  

Body Diagram on Reverse
## Palliative Performance Scale (PPSv2) version 2

<table>
<thead>
<tr>
<th>PPS Level</th>
<th>Ambulation</th>
<th>Activity &amp; Evidence of Disease</th>
<th>Self Care</th>
<th>Intake</th>
<th>Conscious Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Full</td>
<td>Normal activity &amp; work No evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>90%</td>
<td>Full</td>
<td>Normal activity &amp; work Some evidence of disease</td>
<td>Full</td>
<td>Normal</td>
<td>Full</td>
</tr>
<tr>
<td>80%</td>
<td>Full</td>
<td>Normal activity with Effort Some evidence of disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>70%</td>
<td>Reduces</td>
<td>Unable Normal Job/Work Significant disease</td>
<td>Full</td>
<td>Normal or reduced</td>
<td>Full</td>
</tr>
<tr>
<td>60%</td>
<td>Reduced</td>
<td>Unable hobby/house work Significant disease</td>
<td>Occasional assistance necessary</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>50%</td>
<td>Mainly Sat/lie</td>
<td>Unable to do any work Extensive disease</td>
<td>Considerable assistance required</td>
<td>Normal or reduced</td>
<td>Full or Confusion</td>
</tr>
<tr>
<td>40%</td>
<td>Mainly in Bed</td>
<td>Unable to do most activity Extensive disease</td>
<td>Mainly assistance</td>
<td>Normal or reduced</td>
<td>Full or Drowsy + Confusion</td>
</tr>
<tr>
<td>30%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Normal or reduced</td>
<td>Full or Drowsy + Confusion</td>
</tr>
<tr>
<td>20%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Minimal to sips</td>
<td>Full or Drowsy + Confusion</td>
</tr>
<tr>
<td>10%</td>
<td>Totally Bed Bound</td>
<td>Unable to do any activity Extensive disease</td>
<td>Total Care</td>
<td>Mouth care only</td>
<td>Drowsy or Coma + Confusion</td>
</tr>
<tr>
<td>0%</td>
<td>Death</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tbody>
</table>
Inpatient Palliative Medicine New Consult Template

1. **ID**

2. **RFR**

3. **HPI/Cancer hx (if applicable)**

4. **PMHx**

5. **Medications – home and hospital (can simply write in brackets after med “home only” or “new in hospital”)**

6. **Allergies, indicate how the allergy manifests itself (eg sulfa drugs causing hives)**

7. **Palliative Review of Symptoms** – include PPS and ESAS scores here as well. Pain, dyspnea, nausea/emesis, bowels, (urinary symptoms), anorexia, hx of weight loss, dysguesia, xerostomia, depression, anxiety, sleep, energy, fatigue, drowsiness, hx of confusion,

8. **Social and Functional History**: I include who the SDM/POA is in this section, as well as ability to perform ADLs/IADLs, whether CCAC is already involved, and whether there is additional insurance for private services.

9. **Code Status**: i) full code, ii) No CPR/no intubation but would accept ICU care (bipap, pressors), iii) DNR/DNI/No ICU but ward-based medical management, iv) symptom-directed measures.

10. **Goals of Care**: This may or may not be appropriate at the first consult. Need to find out about the person in order to understand what quality of life means to them. What gives them meaning in their life? What “trade offs” are they willing to make? Use concrete examples rather than abstraction.

11. **Physical Exam**: Always do overall appearance, including vitals (if appropriate), look for jaundice, cyanosis, pallor, edema. Comment on cognition, use CAM (eg “CAM positive” or “CAM negative”) and elaborate if positive – i.e. hypoactive vs. agitated vs. mixed, hallucinations, subtle confusion vs. florid delirium. Comment on work of breathing, presence or absence of opioid toxicity if patient is on opioids, and perform a FOCUSED physical exam if necessary.

12. **RELEVANT investigations and imaging**

13. **Summary**

14. **Recommendations**
New Palliative Consult Template

Name
Patient chart number
CC list

DIAGNOSIS: [current diagnosis]

Dear Dr.

Thank you for the referral of this ___ with a diagnosis of ____ to the palliative care clinic for [pain/sx mgmt. or GOC or planning or transition etc]. She/He was seen in the CCSEO on ___ and was accompanied by ____. I saw him/her in the company of ____ between [time].

Cancer hx/HPI

Other PMHx

Medications/Allergies

Palliative ROS including ESAS (completed electronically) – pain [all OPQRST], dyspnea, N/V, appetite/intake, bowels, urinary sx, energy, fatigue, drowsiness, mood, sleep, confusion/cognitive status [+/- sexual concerns, burping, hiccups, pruritis, medication/systemic therapy S/E]

Social Hx/Functional Hx/? CCAC services?

GOC/Code Status/POA or SDM

O/E including vitals and weight (completed by RN), overall appearance, mental status (if applicable), cognition (CAM + or -), and focused physical exam. INCLUDES PPS.

Relevant Recent investigations/Imaging

Summary

Plan (meds, referrals to other MDs/interprofessional services, tests/Ix, non-pharm interventions)

Follow-up apt, He/She knows how to reach the clinic in the meantime should any issues arise.

Thank you for involving me in the care of this patient.
Repeat Clinic Visit Palliative Template

Name
Patient chart number
CC list

DIAGNOSIS: [List of diagnoses]

Dear Dr.

I saw ___ in the palliative care clinic on ____ for a follow up visit. As you know, we are following him/her for symptoms related to his/her diagnosis of ______. He/She was last seen in the CCSEO on ____. Today, he/she and was accompanied by ____, and I saw him/her in the company of Dr. X____ between [time].

Interim Cancer Hx/HPI

Medications

Palliative ROS including PPS, ESAS (completed electronically) – pain [all OPQRST], dyspnea, N/V, appetite/intake, bowels, urinary sx, energy, fatigue, drowsiness, mood, sleep, confusion/cognitive status [+/- sexual concerns, burping, hiccups, pruritis, medication/systemic therapy S/E]

O/E including vitals and weight (completed by RN), overall appearance, mental status (if applicable), cognition (CAM + or - ), and focused physical exam.

New Investigations/Imaging since last appointment

Summary

Plan (meds, referrals to other MDs/interprofessional services, tests/Ix, non-pharm interventions)

Follow-up apt, He/She knows how to reach the clinic in the meantime should any issues arise.

Thanks you for involving me in the care of this patient.