VERMONT

Department of Health

Pediatric Palliative Care Program

INTAKE AND NEEDS ASSESSMENT

REFERRAL INFORMATION

Patient's Name: Date:

Assessor's Name: Agency:

Referral Source: Date of Referral:

Reason for Referral:

DEMOGRAPHIC INFORMATION

PARTICIPANT INFORMATION

Patient's Preferred Name: ☐ M ☐ F DOB:

Age: ☐ mos ☐ yrs School: Grade:

Address: Phone:

Primary Language: Interpreter Required? ☐ yes ☐ no

Eligible Diagnosis: IDC-10:

FAMILY INFORMATION

Primary Caregiver(s): Legal Guardian? ☐ yes ☐ no

Relationship: Primary Language: Interpreter needed? ☐ yes ☐ no

Date: Patient Initials:

FAMILY INFORMATION, CONT'D

DCF Involved?
☐ yes ☐ no If yes, Case Worker: Phone:

OTHER FAMILY MEMBERS			
NAME	RELATIONSHIP & AGE	LIVES WITH CHILD	PROVIDES DIRECT CARE
		☐ yes ☐ no	☐ yes ☐ no
		☐ yes ☐ no	☐ yes ☐ no
		☐ yes ☐ no	☐ yes ☐ no
		☐ yes ☐ no	☐ yes ☐ no
		☐ yes ☐ no	☐ yes ☐ no

MEDICAL HISTORY

DIAGNOSIS LIST		
DIAGNOSIS	ICD:10	ONSET

HOSPITALIZATION/ER VISIT HISTORY		
DATE	REASON	HOSPITAL

MEDICAL HISTORY, CONT'D

CURRENT SCHEDULED MEDICATIONS				
NAME	DOSE	FREQUENCY	ROUTE	INDICATION

CURRENT PRN MEDICATIONS				
NAME	DOSE	FREQUENCY	ROUTE	INDICATION

REVIEW OF SYSTEMS

GENERAL:
☐Alert ☐Oriented ☐Appropriately Interactive ☐Failure to Thrive ☐Fatigue
☐Weight Loss ☐Weight Gain ☐Activity Intolerance ☐Change in Mood
☐Frequent Infections ☐Decreased Consciousness ☐Other:

COMFORT:
☐Pain ☐Itching ☐Dry Mouth ☐Mouth Sores ☐End Stage Restlessness
☐Other:

COMMUNICATION:
☐Age Appropriate/WNL ☐Visually Impaired ☐Blind ☐Hearing Impaired ☐Deaf
☐Nonverbal ☐Augmentative Communication Device ☐Sign Language
☐Other:

RESPIRATORY:
☐WNL ☐Apnea ☐Dyspnea ☐Tachypnea ☐Tracheostomy ☐Suctioning ☐Snoring
☐Hemoptysis ☐Other:

CARDIOVASCULAR:
☐WNL ☐Cyanosis ☐Mottling ☐Arrythmia ☐Diaphoretic with Feeds
☐Congenital Defect ☐Dyspnea with Exertion ☐Dyspnea at Rest ☐Edema
☐Syncope ☐Palpitations ☐Other:

REVIEW OF SYSTEMS, CONT'D
GASTROINTESTINAL: ☐WNL ☐Nausea ☐Vomiting ☐Gastrointestinal Tube ☐Diarrhea ☐Constipation ☐Reflux ☐Ostomy ☐Aspiration Risk ☐Dysphagia ☐Change in Appetite ☐Other:
NEUROLOGIC: ☐WNL ☐Confusion ☐Disorientation ☐Seizures ☐Developmental Delay ☐VP Shunt ☐Spasticity ☐Other:
MUSCULOSKELETAL: ☐WNL ☐Nonambulatory ☐Scoliosis ☐Wheelchair Dependent ☐Contractures ☐Hypotonic ☐Partial Transfer Assist ☐Total Transfer Assist ☐Other:

What is your understanding about your child's illness/condition and his/her prognosis?

What treatment is your child currently receiving or are you considering?

What are the goals of treatment (cure, symptom relief, life-prolonging, palliative, etc.?

Date: Patient Initials:

PHYSICAL ASPECTS OF CARE

Is your child experiencing any pain or discomfort currently? ☐yes ☐no

a) If yes, how are these symptoms being addressed? Is it working? ☐yes ☐no

b) What pain scale does your child use? Or how do you know when he/she is in pain?

Do you feel comfortable managing your child's medical care at home? ☐yes ☐no

Do you understand what medications your child is on and when to give them? ☐yes ☐no

How often do you have to bring your child to the ER because of pain or discomfort?
☐Never ☐1-2x per year ☐3-4x per year ☐Every other month ☐At least every month

Is your child admitted to the hospital frequently? ☐yes ☐no

a) Are these admissions planned or unplanned? Please elaborate:

What are the challenges in caring for your child's physical well-being at home?

What would help you better care for your child at home, if anything?

Date: Patient Initials:

PSYCHOSOCIAL/EMOTIONAL SUPPORT

Is your child aware/informed of his/her diagnosis and/or prognosis? ☐yes ☐no
If yes, what has he/she been told?

What have other children in the family been told?

How is your child coping emotionally?

What have you found to be helpful for your child?

What relationships are most important to your child? (Examples: Best friends, clergy, teachers, family)

How are you and other family members coping emotionally?

What supports has your family found to be helpful in the past and presently?

Date: Patient Initials:

SPIRITUAL AND CULTURAL ASPECTS OF CARE

Is your family part of a faith community or church? ☐yes ☐no

a) If yes, place of worship:
b) If no, do you have a personal belief system or is your family spiritual? ☐yes ☐no

Is there anything about your faith/beliefs that we should know to help our program support your family? ☐yes ☐no If yes, please explain:

Is there anything about your cultural beliefs that you would like to share so we can better support your family? ☐yes ☐no If yes, please explain:

COMMUNICATION AND DECISION MAKING

In your family, who makes the healthcare decisions for your child?

Would your child like to be involved in their healthcare decisions? ☐yes ☐no

Do you prefer to hear as much information as possible, or would you rather ask questions and get answers when you are ready?

Have you discussed your goals for your child's care as a family? ☐yes ☐no
If yes, is your child's medical team aware of your goals and wishes? ☐yes ☐no
If no, would you like to explore this in an upcoming visit? ☐yes ☐no

Have you put these goals in writing or completed any of the following? ☐yes ☐no
☐My Wishes/Voicing my Choices ☐COLST (Clinician Order for Life Sustaining Treatment)
If yes: ☐Attempt Resuscitation/CPR/Full Code
☐Do Not Attempt Resuscitation (DNAR)
☐Refer to COLST for additional information

CONTEXTUAL ASPECTS OF CARE

Are there any important events or celebrations happening that are important to your child and family? (Examples: birthday parties, vacations, weddings, etc.)

Are there any physical restrictions or challenges with the home that create a barrier to caring for your child? (Examples: care is too physically demanding, child's bedroom is not accessible, etc.)

Are there any financial or legal issues that you are concerned about that you would like to discuss?

Do you have any other concerns we haven't addressed? (transportation, school, insurance, equipment, etc.)

PPCP CARE COORDINATOR:

SIGNATURE: **DATE:**

Date: Patient Initials: