VERMONT

Department of Health

PEDIATRIC PALLIATIVE CARE PROGRAM

MONTHLY SERVICE REPORT

NAME:		DOB:	
NURSE CARE COORDINATOR:			
EXPRESSIVE THERAPISTS:			
MSW/BEREAVEMENT:			
DISEASE PROCESS:			
OTHER SERVICES:			

MONTHLY REVIEW		
CARE COORDINATOR VISIT	☐IN PERSON VISIT ☐TEXT/EMAIL CONTACT ☐TELEHEALTH VISIT ☐ATTEMPTED COMMUNICATION/NO REPLY ☐NO CONTACT/REASON:	
ADVANCE CARE PLANNING	☐FULL CODE ☐DNR/COLST IN PLACE	
ER VISITS	☐YES ☐NO DATE/REASON:	
EMERGENCY/AFTER HOURS PLAN IN PLACE	☐YES ☐NO	
HOSPITALIZATIONS	☐YES (☐PLANNED ☐UNPLANNED) ☐NO DATE: REASON: PROCEDURE: DISPOSITION:	
UPCOMING APPTS:	DATE:	PROVIDER:
MEDICATION CHANGES:		
SYMPTOM MANAGEMENT:	☐PAIN ☐FATIGUE ☐RESPIRATORY SYMPTOMS ☐SECRETION CONTROL ☐NAUSEA ☐VOMITING ☐NUTRITIONAL CONCERNS ☐OTHER:	☐CONSTIPATION ☐DIARRHEA ☐ANXIETY ☐DEPRESSION ☐INSOMNIA ☐AGITATION ☐FATIGUE/ACTIVITY INTOLERANCE
CHANGE IN CONDITION:		

Date:

PSYCHOSOCIAL UPDATES:	
EXPRESSIVE THERAPY UPDATES:	
COMMUNICATION WITH PROVIDERS/TEAM	

NOTES:	

SUBMITTED BY: DATE:

Date: