VERMONT

Department of Health

Pediatric Palliative Care Program

TEAM MEETING/FAMILY CONFERENCE NOTE

PATIENT: DOB:

DIAGNOSIS:

CARE TEAM PARTICIPANTS

☐ SEE SIGN IN SHEET FOR ATTENDANCE RECORD AND CONTACT INFORMATION

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

UPDATES

PROVIDER:	
CURRENT STATUS	
NEXT STEPS	
NEXT APPT.	
PROVIDER:	
CURRENT STATUS	
NEXT STEPS	
NEXT APPT.	

Date: Patient Initials:

VERMONT

Department of Health

PROVIDER:	
CURRENT STATUS	
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Date:

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ACTIVE SYMPTOMS

- ☐ Fatigue/Activity Intolerance
- ☐ Respiratory Symptoms
- ☐ Secretion Control
- ☐ Nausea
- ☐ Vomiting
- ☐ Anorexia
- ☐ Pain
- ☐ Diarrhea
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Agitation
- ☐ Constipation
- ☐ Other:

How are these symptoms being addressed?	
SYMPTOM	INTERVENTION

CURRENT CONCERNS

FAMILY CONCERNS:

PROVIDER CONCERNS:

Date:

Patient Initials:

FOLLOW-UP/NEXT STEPS

TASK:	ASSIGNED TO:

NOTES

PPCP CARE COORDINATOR:

SIGNATURE: **DATE:**