

Patient's Initials:

DOB:

PEDIATRIC PALLIATIVE CARE PROGRAM

APPENDIX C: Monthly Service Report

Directions: Please complete monthly for each child enrolled and submit to the Pediatric Palliative Care Nurse Case Manager via fax 802-863-6344.

Child's Name: Click here to enter text.

Date: Click here to enter text.

Pediatric Palliative Nurse Care Coordinator Name: Click here to enter text.

Home Health/Hospice Agency: Click here to enter text.

History of Present Illness (brief summary of updated clinical information): Click here to enter text.

I. SERVICES

What type of care coordination was provided this past month? Check all that apply.

Home Visit (Face-to-Face)

Electronic

Telephonic

Other: Click here to enter text.

With whom did you coordinate care this past month? Check all that apply.

Child's Family

School

Primary Care Provider

Other: Click here to enter text.

What other PPCP services did the child/family receive this past month? Check all that apply.

Family Training

Family Counseling

Expressive Therapy

Skilled-Respite

II. AFTER HOUR/EMERGENCY PLANNING

Does the child have an active after-hours plan? Yes No

Did the child have to go to the ER this past month? Yes No

If yes, briefly explain reason, intervention, and outcome: [Click here to enter text.](#)

Was the child admitted to the hospital this past month? Yes No

If yes, was it a planned admission? Yes No

III. PAIN AND SYMPTOM MANAGEMENT

Did the child have any of the following symptoms this last month? Check all that apply.

- | | | |
|---|---------------------------------------|---|
| <input type="checkbox"/> Pain | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Respiratory Symptoms | <input type="checkbox"/> Constipation | <input type="checkbox"/> Agitation |
| <input type="checkbox"/> Secretion Control | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Fatigue/Activity Intolerance |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Other _____ |

If yes, how are these symptoms being addressed? [Click here to enter text.](#)

IV. CARE PLAN

Does the child have a current plan of care including the key PC elements*? Yes No

Does the child have advanced care directives? Yes No

Feel free to provide any additional communication as needed or desired: [Click here to enter text.](#)

**See Appendix B: Key Elements of a Pediatric Palliative Care Plan*