



Date:

Pediatric Palliative Care Program

Interdisciplinary Team Meeting

DATE:
COUNTY:
ATTENDEES:
DEATHS:
DEATHS.
DISCHARGES.
DISCHARGES:
REFERRALS/ADMISSIONS PENDING:
NEW ADMISSIONS:
ROUTINE PATIENT REVIEWS:



Department of Health

Name:	DOB:
Nurse Care Coordinator:	
Expressive Therapist:	
MSW/Bereavement:	
Disease Process:	
Symptom Management:	
Other Services:	
ER Visit this month? □yes	□no Reason:
Hospital admission? \square yes	\square no Was the admission planned? \square yes \square no
Notes:	
Name:	DOB:
Nurse Care Coordinator:	
Expressive Therapist:	
MSW/Bereavement:	
Disease Process:	
Symptom Management:	
Other Services:	
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MSW/Bereavement:	
Disease Process:	
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Symptom Management:	
Other Services:	
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Hospital admission? ☐ yes	\square no Was the admission planned? \square yes \square no
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Department of Health

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MSW/Bereavement: Disease Process:	
Disease Process:	
Company Managaman	
Symptom Management:	
Other Services:	
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Hospital admission? ☐ yes	\square no Was the admission planned? \square yes \square no
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Department of Health

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MSW/Bereavement:	
Disease Process:	
Symptom Management:	
Other Services:	
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MSW/Bereavement:	
Disease Process:	
Symptom Management:	
Other Services:	
ER Visit this month? □yes	□no Reason:
Hospital admission? □yes	
Notes:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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Nurse Care Coordinator:	
Expressive Therapist: MSW/Bereavement:	
Disease Process:	
Disease Frocess.	
Symptom Management:	
Symptom Management:	
Other Services:	
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Hospital admission? \square yes Notes:	\square no Was the admission planned? \square yes \square no
INULES.	

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