NEAR NORTH PALLIATIVE CARE NETWORK
Main Office at St. Joseph's Motherhouse
2025 Main Street West, North Bay, Ontario, P1B 2X6
Phone: 705-497-9239/1-800-287-9441/Fax: 705-497-1039
Sturgeon Falls: 705-753-3110 ext.339
E-mail: vc@nnpcn.com Website: www.nnpcn.com

ASSESSMENT - PALLIATIVE CARE CLIENT

Date: ____________________ ***Client #***___________________

Patient Information (Personal)				PLEASE PRINT
Last Name:		**First Name:**		
Mailing Address/Box #:		**City/Province:**		
Postal Code:	**Phone Number:**	**Client's date of Birth** ____________ Mon/Day/Year	**Age:**	**Living Alone:** Yes ☐ No ☐

Substitute Decision Maker:	**Relationship:**	**Home Phone Number:**	**Work Phone Number:**
Mailing Address:		**City/Province:**	**Postal Code:**

Family Doctor: Phone Number:	**House Calls:** Yes ☐ No ☐

Family & Significant Other(s) Support:	Mailing Address:	City / Prov / Postal Code:	Home Number: Cell Number:
Pet: Yes ☐ No ☐	**Pet Name:**	**Pet Type:**	**Pet Disposition or Comments:**
Language Spoken:	**Client's Cultural Background:**		
Smoking in Home: Yes ☐ No ☐	**Oxygen:** Yes ☐ No ☐	**Infection Control:**	

ASSESSMENT PALLIATIVE CARE CLIENT

Client's Name: **Client's Number:**

Additional Information:

"Bill of Rights" Yes ☐ No ☐ Medications/Gift Policy Yes ☐ No ☐ Complaints Policy & Procedure Yes ☐ No ☐	Break-through Medication will be Administered by: (who can we call if client needs medication) Name: Phone Number:
Abilities of Daily Living:	Special Interests/Hobbies:
Mental Status:	Mobility Aids: Yes ☐ No ☐ Assistance: Yes ☐ No ☐
Rest /Sleep Routine:	
Patient, Family and Staff Concerns:	
Nutrition: Difficulty Swallowing? Yes ☐ No ☐	Dentures: Yes ☐ No ☐ Glasses: Yes ☐ No ☐ Hearing Aid: Yes ☐ No ☐
Skin Condition:	Bowel/Bladder:

Support in Place at this Time:	Spiritual Advisor/Confidante	Phone No.
Nursing:		
Home-Making:		
How can we help?		
Volunteer Preference: MALE: ☐ FEMALE: ☐ EITHER: ☐	Complimentary Therapies: Yes ☐ No ☐	

INSTRUCTIONS IN CASE OF EMERGENCY, CHANGE IN CONDITION OR DEATH: (Who do we call and how can you be reached)
EMERGENCY NUMBERS POSTED ON REFRIGERATOR Yes ☐ No ☐ IF NOT PLEASE SPECIFY LOCATION OF EMERGENCY NUMBERS: ______________________

Office Information:

Communication Book in Place: Yes ☐ No ☐	NNPCN Contact:	Assessed by:	Assessment Date:
Referral Date:		Date Received	
Referral Agency:	Contact/Case Manager:		Phone Number: