NEAR NORTH PALLIATIVE CARE NETWORK
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ASSESSMENT CHECKLIST PALLIATIVE CLIENT

1. Call client to arrange an assessment appointment. Explain all services and ask if they would like you to bring supplies such as sheepskin, slipper bed pan, baby monitor, etc.

2. Attend assessment taking with you:

   a. Communication Package – your package should include:
      - Client Consent to Obtain & Release Info form
      - Assessment form
      - Care Plan – Palliative Client form
      - Client Case Notes
      - Bill of Rights
      - Client Complaint form
      - Calendar
      - Loan Cupboard supplies
      - Other information pamphlets
      - Our Organizational Pamphlets (In both French and English)
      - Complaints policy and procedure
      - Medication/gift policy and procedure
      - Care for the Caregiver Book (if needed)

   b. If supplies requested, take along Material Loan sign out sheet

3. Date of Assessment/first meeting

4. Fill in assessment form:
   - Important to know if "Dr. makes house calls";
   - "employment" means where the client worked;
   - "patient and family concerns" can be filled in at end of appointment, or as identified;

- "Complimentary Therapies"- volunteers are trained in Therapeutic Touch for relaxation and comfort. ***Note: not many at present time***;
- Important to complete "Instructions in case of Emergency" and identify "emergency numbers" location.
- Go over the contents of the pamphlets included in "Communication Package" – ***important to do this at the end of assessment when you know the client and family comfort level with diagnosis and prognosis.***

5. Review Complaints policy and procedure;

6. Review Medication/gift policy and procedure;

7. Have client sign Client Consent Form to share info with necessary service providers. Complete Care Plan with client and/or Substitute Decision Maker (SDM). Note: Both volunteer and client/SDM must sign completed Care Plan. Also Care Plan must be completed once a month or more frequently if required.

8. Leave Communication Package with the client and/or combine Care Plan with Chart in the Home. (Yellow Binder)

9. Office to contact Team Leader or staff to relay assessment info and care plan, schedule, etc. Care plan must be completed once a month or more frequently, if required.