Réseau de soins palliatifs du Moyen-Nord
NEAR NORTH PALLIATIVE CARE NETWORK
Rue Main Ouest, no. 2025, North Bay, ON, P1B 2X6
2025 Main Street West, North Bay, ON, P1B 2X6
(705) 497-9239 1-800-287-9441
Télécopieur/Fax: (705) 497-1039
office@nnpcn.com http://nnpcn.com/

Ontario

ASSESSMENT - PALLIATIVE CARE CLIENT

Date: ***Client #***

Client Information (PLEASE PRINT)			
Last Name:		**First Name:**	
Mailing Address/Box #:	□ **House** □ **Apartment** □ **Long-term care home**	**City/Province:**	
Postal Code:	**Phone Number:**	**Client's Date of Birth:** **DD/MM/YYYY**	
Living Alone: Yes □ **No** □ **Home Members:**		**Frequent Visitors:**	

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

Primary Physician: **Phone Number:**		**House Calls:** Yes □ No □ DNR Yes □ No □	
Family & Significant Other(s) Support:	**Mailing Address:**	**City / Prov / Postal Code:**	**Home Number: Cell Number:**

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Language Spoken:	**Client's Cultural Background:**	**Bereavement Supports:**
Smoking in Home: Yes □ No □ **Oxygen:** Yes □ No □	**Infection Control/Contagious Illnesses in Home:** **COVID-19 vaccination: 1st dose:** _ **2nd dose:**	

Primary Diagnosis:	**Secondary Diagnoses:**
Break-through Medication will be Administered by: □ **N/A** **(who can we call if client needs medication)** **Name:** **Phone Number:**	**Date of last hospital visit:** **Admission:** □**Yes** □ **No** **Any falls in last 6 months?**
Abilities of Daily Living **Eating:** **Dentures:** **Bathing:** **Dressing:** **Toileting:** **Continence:** - **Bowel:** - **Bladder:** **Person Hygiene:** **Transferring:** **Mobility Aids:** **Yes** □ **No** □ **Assistance with Mobility:** **Yes** □ **No** □ **Glasses:** **Yes** □ **No** □	**Special Interests/Hobbies:** **Participation in social, religious, occupational, and other preferred activities (any changes recently?):**
Communication Level and Ability **Understands others:** **Ease of being understood:** **Hearing aids: Yes** □ **No** □	**Mental Status:**
Mood/Behavior: .	**Rest /Sleep Routine:**
Skin Condition:	

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Support in Place:	**Spiritual Advisor/Confidante**	**Phone No.**
Nursing:		
Homemaking:		
How can we help/ Patient & Family Concerns?		
Volunteer Preference: MALE: ☐ **FEMALE:** ☐ **EITHER:** ☐		
Environmental Assessment:		
Any safety concerns?		

Pet: Yes ☐ **No** ☐	**Pet Name:**	**Pet Type:**	**Pet Disposition or Comments:**

How would you rate the level of your home hygiene?

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:

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