CareBridge
KEEP GOING

Palliative Care Screening Tool

Client Name: _____

DOB: _____

Phone #: _____

Palliative Care Consult: _____

Physician signature: _____

Does the client have any of the following? (circle all that apply)

1) **Advanced illness or new diagnoses of life limiting diseases.**

- Heart Disease (CHF, CAD)
- Dementia
- Parkinson's Disease or other Progressive Neurological Disease
- COPD
- CVA
- Cancer
- Liver or Kidney Disease
- Other chronic Disease

_____Check here any illness circled

If so, do they have any of the following? (circle all that apply)

2) **General Indicators**

- >2 Hospitalizations in the past 6 months, or > 3 ER visits for the same reason
- Bed bound
- Decubitus ulcers
- Not eating/drinking enough to sustain current weight
- Significant functional decline over the past 3 months
- Recurrent aspiration

_____Check here any indicator circled

3) **Symptom Management (circle all that apply)**

- Pain
- Shortness of breath
- Anxiety
- Agitation/restlessness
- Lack of appetite
- Constipation/diarrhea

_____Check here any symptom circled

4) **Psychosocial issues (circle all that apply)**

- Caregiver stress
- Uncertainty regarding prognosis
- Challenging expectations of patient or family
- Lack of Advance Directives and/or identified Health Care decisions maker
- Adjustment issues
- Limited Social Support

_____Check here any psych issue circled

If a client has 2 or more checks in categories 2, 3 or 4, a Palliative Care consult maybe appropriate,
please complete client information at top and fax this form to 513-528-8151 to enable an order for service to be requested.

7625 Camargo Road
Cincinnati, OH 45243

www.carebridgeservices.org

Phone: 513-528-8150
Fax: 513-528-8151