PIH/MOH Malawi
Palliative Care Program

INITIAL ASSESSMENT FORM

A. Demographics

Last Name:_____

First Name:_____

Birthdate (Day/Month/Year): ___/___/_____

Age: _____ EMR #: _____

Sex: ☐ F ☐ M Marital Status:_____

Caregiver/Next of Kin:_____

_____

Village:_____

Referred From: ☐ CCC ☐ KS Clinic ☐ OPD

☐ Health Center ☐ Hospital Ward

☐ Other (Specify):_____

Reason for Referral:_____

_____

_____

B. Medical History

Presenting Concerns:_____

Diagnosis:_____

Prognosis:_____

HIV Status: ☐ Reactive ☐ Nonreactive ☐ Not Tested

Diagnosis Discussed with Patient: ☐ Yes ☐ No Diagnosis Discussed with Caregiver: ☐ Yes ☐ No

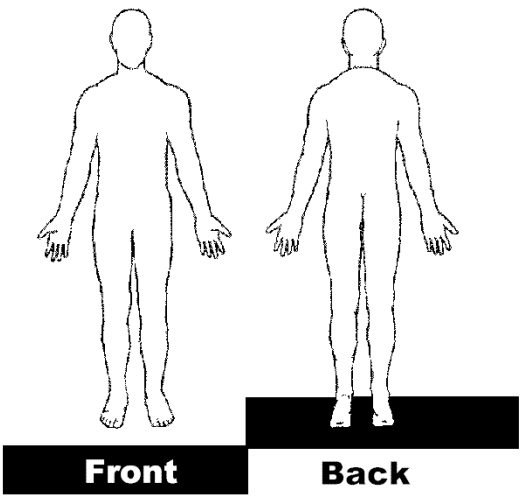
Past Medical History:_____

_____

History Given By: ☐ Patient ☐ Caregiver ☐ Other (Specify):_____

C. Physical Exam

General	Abdominal
Weight	Extremities
Pulmonary	Neurological
Cardiac	Musculoskeletal



D. Palliative Care Outcomes Scale *(Use Visual Symptom Scale Below)*

Ask the <u>patient</u> to rate the following from 0 (not at all/nothing) to 5 (very much/everything):

1) Please rate your pain during the last 3 days: _____ (0-5)

2a) Have you had any other symptoms that have been affecting you for the last 3 days? _____ (0-5)
2b) If so, please rate each symptom during the last three days (Specify Symptoms Below):

_____ _____ (0-5)

_____ _____ (0-5)

_____ _____ (0-5)

3) Have you been feeling worried about your illness in the past 3 days? _____ (0-5)

4) Over the past 3 days, have you been able to share how you are feeling with your family or friends? _____ (0-5)

5) Over the past 3 days have you felt that life was worthwhile? _____ (0-5)

6) Over the past 3 days, have you felt at peace? _____ (0-5)

7) Have you had enough help and advice for your family to plan for the future?_____ (0-5)

Ask the <u>family/caregiver</u> to rate the following from 0 (not at all/nothing) to 5 (very much/everything):

8) How much information have you and your family been given?_____ (0-5)
9) How confident does the family feel caring for ____ (the patient)?_____ (0-5)
10) Has the family been feeling worried about _____ (the patient) over the last 3 days?_____ (0-5)

Visual Symptom Scale

0 = None **5 = Very Much**

E. Pain Management *(Use Visual Symptom Scale Above)*

Pain Severity (From 0 to 5):_____ (0-5)

Duration:_____

Description of Pain:_____

_____

_____

Pain Affects: Sleep? ☐ Y ☐ N Mobility? ☐ Y ☐ N

Current Pain Medication(s):_____

_____

Effect of Current Medication(s): ☐ None

☐ Partial Control ☐ Complete Control

F. Management Plan

Patient Referred to POSER for evaluation? ☐ Y ☐ N

Problem:	**Plan:**
Problem:	**Plan:**

Completed By:_____ **Date: ___/___/_____**