

Palliative Patient Status Update

NAME: _____

CASELOAD: _____

ADDRESS: _____

HCN/BRN: _____

DATE d/m/y: _____ ATTENTION: _____

PPS%: _ Pain scale: ___/10

Current Pain Regime:

Areas of Concern:

Suggestion of Treatment Orders:

Additional Information:

SIGNATURE: _____

DESIGNATION: _____

AGENCY _____

PHONE NUMBER: _____

RESPONSE OR ORDERSResponse Required: YES NO

South West LHIN Fax Number: LME:519-472-3257; Oxford:519-539-6351;Huron-Perth:519-273-6454;Grey-Bruce:519-881-1425

PLEASE FAX RESPONSE TO: _____

SIGNATURE: _____ DESIGNATION: _____

DATE: d/m/y. _____ NEXT APPOINTMENT: _____