

1 Patient Information

1 PATIENT DETAILS

Name:	_____	Date of Service:	_____
DOB:	_____	Provider:	_____
Age / Sex:	_____	MRN:	_____
Visit Type:	_____	Primary Diagnosis:	_____
Care Setting:	_____		_____

CC Chief Complaint

2 PRIMARY REASON FOR ENCOUNTER

Symptom management, goals-of-care discussion, advance care planning, serious illness support, or care coordination...

S Subjective

3 PATIENT-REPORTED SYMPTOMS, GOALS & INTERVAL HISTORY

3a SERIOUS ILLNESS HISTORY / INTERVAL STATUS

Underlying illness, disease trajectory, recent decline, hospitalizations, treatment changes, and current clinical concerns...

3b SYMPTOM BURDEN

Pain:	_____	Dyspnea:	_____
Nausea / Vomiting:	_____	Constipation:	_____
Fatigue / Weakness:	_____	Anorexia:	_____
Insomnia:	_____	Anxiety / Depression:	_____
Agitation:	_____	Secretions / Other:	_____

3c SYMPTOM SEVERITY & IMPACT

Quantify symptom severity and describe impact on function, sleep, appetite, mobility, ADLs, and quality of life...

3d CURRENT TREATMENT RESPONSE

Response to analgesics, antiemetics, bowel regimen, anxiolytics, oxygen, steroids, or other supportive treatments...

3e PATIENT / FAMILY GOALS & PREFERENCES

Patient values, understanding of illness, treatment goals, acceptable quality of life, and preferences regarding comfort-focused vs. disease-directed care...

3f PERTINENT NEGATIVES

Absence of uncontrolled pain, respiratory distress, severe agitation, suicidal ideation, or other urgent concerns...

O Objective

4 MEASURABLE & OBSERVED FINDINGS

V VITAL SIGNS

Temperature: _____ Blood Pressure: _____
Heart Rate: _____ Respiratory Rate: _____
Oxygen Saturation: _____ Weight: _____
Pain Score: _____ Performance Status (ECOG / PPS / Karnofsky): _____

4a PHYSICAL EXAMINATION

General Appearance: _____ Mental Status: _____
Cardiovascular: _____ Respiratory: _____
Abdomen: _____ Neurological: _____
Skin: _____ Musculoskeletal: _____
Psychosocial / Emotional Presentation: _____

L Lab & Imaging Results

5 CLINICALLY RELEVANT REVIEWED DATA

5a LABORATORY STUDIES

CBC, CMP, renal/hepatic function, electrolytes, albumin, inflammatory markers, or labs influencing symptom management...

5b IMAGING STUDIES

CT, MRI, X-ray, ultrasound, or disease-monitoring imaging relevant to prognosis or symptom burden...

5c OTHER CLINICAL DATA

Hospital course, consult notes, medication administration record, code status documentation, or prior advance care planning documents...

A Assessment

6 PALLIATIVE CARE CLINICAL INTERPRETATION

Serious illness diagnosis and disease trajectory. Current symptom burden and level of control. Functional status and prognosis considerations. Psychosocial, spiritual, or caregiver support needs. Patient/family understanding of condition. Alignment or misalignment between current treatment plan and stated goals...

P Plan

7 PALLIATIVE MANAGEMENT

7a SYMPTOM MANAGEMENT

Medication changes and non-pharmacologic interventions. Pain management and bowel regimen if opioids are used...

7b REFERRALS & CARE COORDINATION

Referrals to hospice, social work, chaplaincy, nutrition, psychology, or home services. Coordination with primary team, specialists, caregivers, or facility staff...

7c PATIENT / FAMILY EDUCATION

Expected disease course, medication use, and warning signs requiring urgent contact...

ACP Advance Care Planning / Goals of Care

8 GOALS-OF-CARE DISCUSSION & DOCUMENTATION

8a PATIENT UNDERSTANDING & DECISION-MAKING

Patient's Understanding of Illness / Prognosis: _____ Healthcare Proxy / Decision-Maker: _____

8b ADVANCE DIRECTIVES & CODE STATUS

Advance Directives (on file / discussed / declined): _____ POLST / MOLST Status: _____

DNR / DNI Status: _____ Treatment Preferences & Limits of Care: _____

8c FAMILY MEETING / ADDITIONAL NOTES

Family meeting details, participants, key decisions made, or outstanding discussions...

F Follow-Up

9 REASSESSMENT PLAN

Follow-up timeframe and purpose: _____

Symptom reassessment, goals-of-care review, family meeting, or hospice transition planning...

TIME DOCUMENTATION & BILLING

Total Time: _____ Counseling / Coordination Time: _____ Advance Care Planning Time: _____ E/M Level: _____

ACP Code (99497 / 99498, if applicable): _____ Basis for Billing: _____

Primary ICD-10 Code: _____ Secondary ICD-10 / Palliative Care Code: _____

PHYSICIAN / PROVIDER NAME	SPECIALTY: PALLIATIVE CARE	DATE	TIME
_____	_____	_____	_____