

**CONSULTATION REPORT**

**SMH 1558 MR**

**Palliative Care Consult Service**

**ATTENDING CONSULTANT'S SUMMARY**

MR#:

DOB:

Patient seen and examined. I agree with the 1557MR database assessment and plan as recorded except as follows:  
(Complete all \* areas for patients seen by NP or medical student)

**Consult Date:** \_\_\_\_\_ **Time** \_\_\_\_\_

**\*Reason for Consult:**

**\*HPI:**

*Please see Palliative Care Database Form SMH 1557 MR for past medical history, psychosocial and family history, palliative care review of systems, performance status, medications, current treatments and lab results.*

**\*Physical Examination:** BP \_\_\_\_\_ T: \_\_\_\_\_ Pulse: \_\_\_\_\_ RR: \_\_\_\_\_ O<sub>2</sub> sat: \_\_\_\_\_

**Check if normal:**

HEENT _____	Pulmonary _____	GI/Abdomen _____	Skin _____
Neck _____	Cardiovascular _____	GU _____	Neurologic _____
Hema/Lymph _____		Musculoskeletal _____	Psychiatric _____

**Abnormalities:** \_\_\_\_\_

**\*Attending Assessment Summary:**

**\*Attending Recommendations:**

(1)

(2)

(3)

(4)

(5)

**TOTAL time spent** \_\_\_\_\_ **minutes.**  Check if > 50% of time was spent in counseling and/or coordination of care.

**SIGNATURE:**

**Attending** \_\_\_\_\_ please print \_\_\_\_\_ signature \_\_\_\_\_ date \_\_\_\_\_

