

**แบบฟอร์มขอรับคำปรึกษาศูนย์การุณรักษ์ (Palliative Care Center)**

ชื่อ-สกุล ผู้ป่วย...........................................................................................อายุ.................ปี HN……...……………………..หอผู้ป่วย....................................

การวินิจฉัยโรค 1.......................................................................................................................................เมื่อ....................................................

 2.......................................................................................................................................เมื่อ....................................................

3.......................................................................................................................................เมื่อ....................................................

ข้อมูลผู้ป่วยอย่างย่อ...............................................................................................................................................................................................

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การตรวจทางห้องปฏิบัติการและผลการตรวจรักษาที่สำคัญ.................................................................................................................................

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ความเร่งด่วนของการปรึกษา ⬜ ปกติ ⬜ ด่วน ระบุ.....................................................

การรับรู้การวินิจฉัยโรค/พยากรณ์โรคของผู้ป่วย ⬜ รู้ ⬜ ไม่รู้ การรับรู้การวินิจฉัยโรค/พยากรณ์โรคของครอบครัว ⬜ รู้ ⬜ ไม่รู้

เหตุผลของการของรับคำปรึกษา ⬜ การจัดการอาการ ⬜ การดูแลด้านจิตสังคมและจิตวิญญาณ ⬜ ยืมอุปกรณ์การแพทย์

 ⬜ การวางแผนการดูแลล่วงหน้า ⬜ ส่งต่อเครือข่ายชุมชนหรือการดูแลต่อที่บ้าน

ลงชื่อ.......................................................................................แพทย์/อาจารย์ ที่ขอรับคำปรึกษา วันที่...............................................

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**Palliative Care Consultation Report**

**HPI Summary:**

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**Physical examination**

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**ESAS (0-10)**

 **PPS…………….%**

Depression……………. Anorexia ……………… Inactivity………………. Dyspnea……………… Anxiety………………………

Nausea ……………………. Drowsiness …………………. Constipation……………………….. Agitaiton……………………. Physical discomfort………………….

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**Psychosocial/spiritual issues:**

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**Advance care plan**: ( ) Done by patient & family ( ) Done by family only ( ) not yet decided

 **Goal of care & End of life management**

 ( ) Comfort care

 ( ) No ETT & ventilator ( ) No CPR

 ( ) No inotrope ( ) No hemodialysis

 ( ) Other……………………………..

 ( ) Full life support & CPR

 ( ) Not yet decided ( ) Other……………………………..

**Problem lists:**

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**Recommendation:**

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 ลงชื่อ..................................................................แพทย์ผู้ให้คำปรึกษา วันที่.............................