

**แบบฟอร์มขอรับคำปรึกษาศูนย์การุณรักษ์ (Palliative Care Center)**

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

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

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

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

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

................................................................................................................................................................................................................................

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

................................................................................................................................................................................................................................

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

................................................................................................................................................................................................................................

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

................................................................................................................................................................................................................................

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

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

................................................................................................................................................................................................................................

................................................................................................................................................................................................................................

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

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

เหตุผลของการของรับคำปรึกษา ⬜ การจัดการอาการ ⬜ การดูแลด้านจิตสังคมและจิตวิญญาณ ⬜ ยืมอุปกรณ์การแพทย์

⬜ การวางแผนการดูแลล่วงหน้า ⬜ ส่งต่อเครือข่ายชุมชนหรือการดูแลต่อที่บ้าน

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

**------------------------------------------------------------------------------------------------------------------------------------------**

**Palliative Care Consultation Report**

**HPI Summary:**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**Physical examination**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**ESAS (0-10)**

**PPS…………….%**

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

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

**Continue on back page**

**Psychosocial/spiritual issues:**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**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:**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**Recommendation:**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

**………………………………………………………………………………………………………………………………………………………………………………………….**

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