TEAM ALERT

Date of First Assessment: ____________ initial: ________

PRACTICAL CONSIDERATIONS

P.O.A.: enduring / bank / other: ___________________________ Who is POA? ___________________________

Decision Maker: ___________________________ Relationship ___________________________ Rep Agreement: yes no

Financial Support/Pensions: Income Assist ☐ CPP (disability) ☐ DVA ☐ Other ___________________________

Financial/Housing/Employment concerns: ___________________________ No financial concerns apparent ☐

Last Will & Testament: Discussed ☐ Estate Plan package given ☐ Will Completed ☐

Funeral Planning: Discussed ☐ F/M Plan package given ☐ Funeral Home ___________________________

TIME OF DEATH

Details __________________________________________________________

Family/others requesting to be present at time of death ____________________________________________

Special requests/rituals for time of death ________________________________________________________

SPIRITUAL CARE

Religious/Spiritual affiliation __________________________________________

Patient’s description of their Spirituality __________________________________________

__________________________________________ Referral for Spiritual Care ☐ Date. ____________

INFORMATION GIVEN: (to whom)

☐ Anticipatory Grief _________________________________________________

☐ Children & Grief ___________________________________________________

☐ When Death Occurs ________________________________________________

☐ Final Gifts _________________________________________________________

☐ Other ___________________________________________________________
Patient Assessment

Life Review (careers, interests, etc.)

Cultural Beliefs & Practices Relevant to Care

Community Supports

Strengths / Coping and Decision-making Styles / Self Care

Current Awareness of Illness / Goals / Expectations / Hopes

Fears / Concerns

Intimacy / Sexuality Issues

Losses experienced by Patient and Family

Anticipated losses
FAMILY MAP

CAREGIVER ASSESSMENT

Primary Caregiver Name __________________________ Relationship _______ Employed _______

Physical/Psych/Medical ____________________________ ____________________________

Strengths/Coping/Self Care ________________________ ____________________________

Concurrent Demands ______________________________ ____________________________

Hopes/Fears/Other ____________________________________________________________

Other Caregiver Name __________________________ Relationship _______ Employed _______

Physical/Psych/Medical ____________________________ ____________________________

Strengths/Coping/Self Care ________________________ ____________________________

Concurrent Demands ______________________________ ____________________________

Hopes/Fears/Other ____________________________________________________________

FAMILY FUNCTIONING (communication patterns, decision making, family roles, etc.)

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________