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.)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________