Case Documentation

Date: _____

Request from:

☐ physician / ☐ nursing staff / ☐ patient / ☐ patient relatives / ☐ rounds / ☐ _____

Name:

Clinic / ward:

Phone Number:

Request received via: ☐ phone / ☐ fax / ☐ E-Mail / ☐ mail

Urgency:
☐ immediately / urgent ☐ within 24 hours
☐ within one week ☐ not urgent
☐ retrospective case review

Patient:

Name:

Sex: ☐ female / ☐ male

Age and Date of birth: _____

Capacity for consent: ☐ yes / ☐ no / ☐ unclear

Advance directives: ☐ Living will
☐ Health care power of attorney

Patient advocate: ☐ Guardianship: _____
☐ Health care power of attorney: _____

Topic / Conflict (Reason for request):

Meeting details:

Date: _____

Format: ☐ case consultation / ☐ facilitated team meeting
☐ facilitated meeting with patient relatives
☐ retrospective case review

Participants:

Moderation:

Details:

Results / Recommendations:

Further course:

Recommendation implemented: ☐ yes / ☐ no

Deceased: ☐ yes (Date _____) / ☐ no

Discharge: ☐ Rehab / weaning station ☐ care facility
☐ hospice ☐ home ☐ transfer clinic / ward

Details: