For Those Undergoing Palliative Care Outpatient Consultation

Please provide the following information which we need to make decisions on your palliative care treatment and future treatment policy. Your information will be handled confidentially. It will not be used for any other purposes than the provision of medical care, and your privacy will be protected.

Name:		Date of birth: YYYY / MM / DD	Age
Person accompanying the patient:			Relation:
Contact information	①telephone number:	（ home ・ mobile ） name:	relation:
	②telephone number:	（ home ・ mobile ） name:	relation:

1. What made you seek care at the Palliative Care Department?

☐Choice of patient ☐Requested by family ☐Recommended by physician
☐Recommended by friend/colleague
☐Other（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

2. Would you like to take a tour of the hospital ward today? ※Available 10AM-12PM and 1:30PM−3:30PM

☐Yes ☐No

3. At present, which of the following symptoms are you suffering from? (Check all that apply)

☐Pain ☐Trouble breathing ☐Coughing ☐Bloating ☐Fatigue
☐Trouble Eating ☐Swelling ☐Trouble Sleeping ☐Constipation ☐Diarrhea
☐Trouble urinating ☐Nausea/vomiting ☐Sleepiness ☐Worrying
☐Feeling depressed ☐Trouble thinking clearly ☐No severe symptoms
☐Other（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

4. Is there anything in addition to your health that you are concerned about?

☐Family （＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）
☐Work （＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）
☐Finances （＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）
☐Other （＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）
☐N/A

5. How has your present condition been explained to you?

6. How has your attending doctor explained the treatment that you will receive from now on?

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7. How has palliative care been explained to you?

8. What are your expectations of palliative care?

9. If you have any questions or concerns about palliative care, please note them here.

10. Please indicate the medical treatments you are currently receiving (Please provide as much detail as possible)

☐Anticancer treatment（_____）

☐Alternative treatments （_____）

☐Gastrostomy ☐Urethral balloon catheter ☐Nephrostomy ☐CV Port ☐High caloric IV

☐Oxygen ☐Stoma ☐Blood glucose monitoring ☐Insulin injections ☐Narcotics for medical use

☐Bedsore treatment ☐Pacemaker ☐Blood transfusions ☐Others (　　)

11. Please provide information on any allergies

☐Yes, I have allergies（_____）

☐No allergies

12. Please provide information on your lifestyle habits.

Smoking history：☐No ☐ Yes (From age_____to_____years, approx. ____cigarettes a day)

Present drinking habit: ☐No ☐Yes (beer:____bottles, rice wine:___go, wine: ___glasses. whisky:___tots/day)

Are you covered by Care/Nursing Insurance?

☐Have not applied ☐Currently applying

☐Have applied（☐Required Care: 1 / 2 / 3 / 4 / 5 ☐Required Support: 1 / 2 ☐Not applicable）

☐Currently under renewal ☐Do not wish to use care/nursing insurance services

☐Care manager（Company：_____ Person in charge：_____ ）

13. Specify the services/items you currently utilize from the following:

☐Home visiting nursing（____times/week） ☐Home visiting care（____times/week）

☐Home visiting doctor（____times/week or ____times/month） ☐Day-care service（____times/week）

☐Bathing assistance（____times/week） ☐Short-stay/Temporary care ☐Home-delivery meals/food

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☐Assistive equipment（☐Wheelchair ☐Care/Nursing bed ☐Shower/bath seat ☐Portable toilet

☐Home renovations （☐Handrails ☐Ramps ☐Other（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

14. Do you have certification for physical disability?

☐ NO ☐YES→Disability category（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）（Level＿＿＿＿＿＿）

15. Please specify any other support services you utilize:

（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

16. Please indicate your occupation. (You may specify if you are retired or on leave).

（＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿＿）

17. At St. Luke's International Hospital, patients are treated with blood transfusion when deemed medically necessary. Do you agree to undergo blood transfusion? ☐ Yes ☐ No（Reason：＿＿＿＿＿＿＿＿＿＿）

18. Do you have any faith or religion? ☐ Yes （＿＿＿＿＿＿＿＿＿＿） ☐ No

19. Family Information

Relative	**Sex**	**Age**	**Living/ Deceased**	**Place of Residence ※Please write the name of city/ward/town**
Father	―		Living/Deceased	Living together / separately (location:)
Mother	―		Living/Deceased	Living together / separately (location:)
Spouse	M / F		Living/Deceased	Living together / separately (location:)
Children	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)
Siblings	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)
	M / F		Living/Deceased	Living together / separately (location:)

20. Is there a person whom you wish to make decisions on your behalf in case you are in a condition in which you cannot make decisions about your treatment yourself?

☐Yes (Name: ＿＿＿＿＿＿＿＿＿＿ Relation: ＿＿＿＿＿＿＿＿) ☐No ☐Unsure

Thank you for your cooperation

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