Capital Health

Capital Health Integrated Palliative Care Service

Vision the Legacy - Admission Assessment

Admission date: _____

Primary diagnosis: _____

Place donor status sticker here

Contraindications:

1. >70 years
2. Leukemia, lymphoma
3. Malignant melanoma
4. Transmissible disease
5. Sepsis
6. ALS, MS, CJD
7. MRSA/VRE positive
8. High risk social behavior for HIV hepatitis

☐ No approach rationale (see contraindications 1 - 8) _____ Other _____

☐ **Suitable for approach** **Page Tissue Bank Specialist on call 473-2222**

Chart reviewed by: _____ Chart review date: _____

DONATION CONVERSATION

Delegate to initiate donation conversation (circle): **Nurse** **Physician** **Other** _____

Education booklet given to Patient/Family: ☐ Yes ☐ No Initial/Status: _____

Patient/Family initiated

↓

☐ Decline ☐ Agreement

Provider initiated

↓

☐ Decline ☐ Agreement

Comments:

_____

_____

See Progress Notes ☐

Date	Name	Signature	Status	Initials

Assessment Forms