Continuous palliative sedation: evaluation and start of sedation

Date (day/month/year): _____/_____/_____
Members of the care team:
1) _____ 2) _____ 3) _____
(Doctor, nurse, healthcare assistant, psychologist, physiotherapist)

Patient (Name and Surname): _____
Date of birth (day/month/year): _____/_____/_____
Sex: Male Female
Date of Hospice admission (day/month/year):____/____/____
Is it this the first admission to a Hospice? Yes No
If NO, has the patient been admitted to a Hospice or Day Hospital of the palliative care unit? _____

Principal diagnosis (neoplastic or non-neoplastic disease):_____
Date of the diagnosis (month/year):_____/_____
Sites of metastases:_____

Refractory Symptom:

Delirium	Massive bleeding
Dyspnea	Convulsions
Vomiting	Existential distress
Severe pain	Other

Specific medical treatment administered for symptom management in the last few hours:

Haloperidol
Clorpromazin
Clothiapine
Delorazepam
Dexamethasone
Diazepam
Furosemide
Midazolam
Methylprednisolone
Morphine
Promazine
Scopolamine
Other

Patient:
Awareness of Diagnosis

Full	Ambivalent
Partial	Absent
Uncertain	Not assessable

Awareness of Prognosis

Full	Ambivalent
Partial	Absent
Uncertain	Not assessable

Did the palliative care team talk about sedation with the patient during hospice admission?
Yes No

i. If yes, did the patient agree to the possibility of sedation? Yes No
ii. If no, why was it not possible to talk about sedation with the patient?

Due to the clinical condition
Due to psychological status

How does the patient tolerate the onset of the refractory symptom?

i. The patient DEFINED the symptom "intolerable":

Never	Often
Seldom	Always

ii. The patient SHOWED (with clinical signs) the symptom to be "intolerable":

Never	Often
Seldom	Always

i. At the onset of the refractory symptom, did the patient understand? Yes No
ii. If yes, did the patient approve the start of sedation? Yes No
iii. Questions, wills, requests_____

Caregiver (CG):

When the refractory symptom arose:

i. Was the CG dissatisfied with the palliative care team's work? Yes No
ii. Frequency of being called to the patient's room? Seldom Recurrent Always
iii. Did the CG asked for sedation early? Yes No
iv. When the palliative care team advised initiating sedation, did the CG approve? Yes No
v. Did the palliative care team talk about SP with the CG during Hospice admission? Yes No
vi. Did the CG approve the beginning of SP? Yes No Ambivalent
vii. Questions, wills, requests_____

Doctor (Name/Surname): _____/_____

Palliative sedation TREATMENT:
Patient (name/surname): _____/_____

At the beginning of sedation:
Date (day/month/year): _____/____/_____
Time of the date (hour/minute): _____:_____
Sedative drug: _____
Dose of sedative drug: _____
Patient's RASS Scale: _____

Maintenance of sedation:
Sedative drug: _____
Dose of sedative drug: _____

If there is an increase in the sedative drug:
Sedative drug: _____
Dose of sedative drug: _____
Patient's RASS Scale: _____

Hydration: Yes No

Date of the death (day/month/year): _____/_____/_____
Time of the day (hour: minute) ____: ____

Appendix 1: Multi-professional medical record of the palliative sedation.