VERMONT

Department of Health

Pediatric Palliative Care Program

Interdisciplinary Team Meeting

DATE:

COUNTY:

ATTENDEES:

DEATHS:

DISCHARGES:

REFERRALS/ADMISSIONS PENDING:

NEW ADMISSIONS:

ROUTINE PATIENT REVIEWS:

Date:

VERMONT

Department of Health

Name:		**DOB:**	
Nurse Care Coordinator:			
Expressive Therapist:			
MSW/Bereavement:			
Disease Process:			
Symptom Management:			
Other Services:			

ER Visit this month? ☐yes ☐no Reason:

Hospital admission? ☐yes ☐no Was the admission planned? ☐yes ☐no

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