

# INTERDISCIPLINARY END OF LIFE ASSESSMENT

## PSYCHO-SOCIAL ASSESSMENT:

### Major Concerns:

- |   |  |
|---|--|
| <input type="checkbox"/> Adequacy of care given | <input type="checkbox"/> Fear of Dying           |
| <input type="checkbox"/> Living Arrangements    | <input type="checkbox"/> Anticipatory Grief      |
| <input type="checkbox"/> Financial Difficulties | <input type="checkbox"/> Anxiety                 |
| <input type="checkbox"/> Poor Communication     | <input type="checkbox"/> Anger                   |
| <input type="checkbox"/> Family Conflict        | <input type="checkbox"/> Guilt                   |
| <input type="checkbox"/> Culture/Spirituality   | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> Legal Matters          | <input type="checkbox"/> Denial of Dying Process |
| <input type="checkbox"/> Other _____            |  |

### Mental Status:

- |  |  |
|--|--|
| <input type="checkbox"/> Guilt               | <input type="checkbox"/> Anger                                     |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Loneliness/Isolation                      |
| <input type="checkbox"/> Thoughts of Suicide | <input type="checkbox"/> Conversational Themes/<br>Thought Content |

Family expectations: \_\_\_\_\_

Client expectations: \_\_\_\_\_

Recommendations/Special Requests: \_\_\_\_\_

Assessor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NUTRITIONAL ASSESSMENT:

1. Which of the following are troubling the client/family?

- |  |   |
|--|---|
| <input type="checkbox"/> Poor food intake      | <input type="checkbox"/> Inability to eat certain foods |
| <input type="checkbox"/> Dry mouth             | <input type="checkbox"/> Sore mouth                     |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Constipation                   |
| <input type="checkbox"/> Diarrhea              | <input type="checkbox"/> Vomiting                       |

2. If nausea, is it associated with:

- |   |   |
|---|---|
| <input type="checkbox"/> Certain foods  | <input type="checkbox"/> Sight of food      |
| <input type="checkbox"/> Smell of foods | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Medications    |   |

3. Are medications taken to control nausea?  Yes  No

If yes, are medications effective?  Yes  No

Recommendations: \_\_\_\_\_

Assessor's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Stamp plate

**NURSING ASSESSMENT:**

**Mental Status:**

Alert     Disoriented     Drowsy     Agitated     Speech clear  
 Oriented     Confused     Lethargic     PERRLA     Vertigo  
 Move Extremities

**Activity Level:**

Amb     W/C     Bed bound     Independent  
 Need assist w/ADL     Walker     Total ADL Care Needs

**Pain Assessment:**

Location of pain: \_\_\_\_\_  
\_\_\_\_\_

Intensity of pain: \_\_\_\_\_  
\_\_\_\_\_

Manner of expressing: \_\_\_\_\_  
\_\_\_\_\_

What relieves the pain? \_\_\_\_\_  
\_\_\_\_\_

What causes the pain? \_\_\_\_\_  
\_\_\_\_\_

Effects of pain:

Nausea     Loss of sleep     Loss of appetite     Irritability  
 Suicidal     Crying     Concentration     Anger

Other: \_\_\_\_\_

Assessor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ACTIVITY ASSESSMENT:**

Music     Reading/writing     Talking/conversing     Table games  
 Coffee     Videos/Television     Spiritual/religious activities  
 Sodas     Crafts/arts     Trips/rides     Gardening  
 Other special needs identified: \_\_\_\_\_  
\_\_\_\_\_

Recommendations: \_\_\_\_\_  
\_\_\_\_\_

Assessor's signature: \_\_\_\_\_ Date: \_\_\_\_\_

