

Interdisciplinary Patient Care Conference Form

Patient: _____

Reason for Admission: _____ Conference Date _____

*P	Clinical Variable	Long Term Goals (Proposed Pt condition at DC)	Projected Goal Date	Interventions	Date Goal Met	Initial/Dept Completing Section
	Medically Complex: <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis	<input type="checkbox"/> Medically Stable for alternative level of care Anticoagulation therapy <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Labs within normal limits				
	Restraint/Safety/Fall	Fall Risk: <input type="checkbox"/> At risk <input type="checkbox"/> Not at risk <input type="checkbox"/> Restraints Type of restraint _____				
	Pain: Alteration in comfort	<input type="checkbox"/> No c/o pain <input type="checkbox"/> Pain controlled by P.O. medication				
	Pharmacy:	<input type="checkbox"/> Pharmaceutical needs addressed <input type="checkbox"/> Appropriate for alternative level of care				
	Infection: <input type="checkbox"/> Isolation <input type="checkbox"/> IV antibiotics	<input type="checkbox"/> No active signs of infection; temp & WBC within normal limits <input type="checkbox"/> Cultures negative <input type="checkbox"/> Secretions clear and odorless				
	Respiratory: Alteration in airway/gas exchange	<input type="checkbox"/> ↓ Need for mechanical ventilation <input type="checkbox"/> Wean to RA <input type="checkbox"/> O2 Exchange improved <input type="checkbox"/> ↓ Wheezing/bronchospasm <input type="checkbox"/> Clear breath sounds/X-ray <input type="checkbox"/> ↓ FiO2 <input type="checkbox"/> ↓ PCO2 <input type="checkbox"/> O2 wean At Risk for Decannulation: <input type="checkbox"/> Y <input type="checkbox"/> N				



Record Identifier:

*P – Numerically Prioritize Problem List in the Patient Care Conference

*P	Clinical Variable	Long Term Goals (Proposed Pt condition at DC)	Projected Goal Date	Interventions	Date Goal Met	Name/Signature Completing Section
	Rehabilitation: Alteration in functional mobility	PT <input type="checkbox"/> Improvement in strength, endurance, balance and mobility				
		OT <input type="checkbox"/> Improvement in performing self-care				
		SLP <input type="checkbox"/> Optimize swallowing function				
	Nutrition: Alteration in nutrition	<input type="checkbox"/> Maintain adequate nutritional intake <input type="checkbox"/> Tolerance of Tube Feeding <input type="checkbox"/> Weight Gain _____ Loss _____				
	Wound: Alteration in skin integrity	<input type="checkbox"/> Wounds improved/stabilized and show signs of healing <input type="checkbox"/> Wound bed clean and healing <input type="checkbox"/> Pt not develop new pressure ulcer				
	Knowledge: Deficit	<input type="checkbox"/> Demonstrate understanding of patient education in area of deficit				
	Discharge Plan: Estimated LOS: Weeks _____ Days _____	Anticipated Discharge Disposition: Anticipated Discharge Date:		Obstacle/Barrier to next appropriate level of care		

ATTENDANCE AT PATIENT CARE CONFERENCE		
Case Management:	Nursing:	Physical Medicine:
Respiratory Therapy:	Dietician:	Wound Care Nurse:
Pharmacy:	Physician:	Family:
Infection Control:	Other(s):	<input type="checkbox"/> Reviewed with Physician <input type="checkbox"/> Reviewed with Family

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