TEMPLATE CHECKLIST

New Patient Note Template Checklist

HPI

- ⊗ How is your overall quality of life?
- ⊗ What is the toughest part of this illness?
- ⊗ What do you enjoy or look forward to?
- ⊗ Thinking about the future, what worries you?

Note: These questions can give you a sense of the values of the person in front of you, highlight palliative concerns, and help you co-create treatment plans that incorporate their values.

- ⊗ If a care partner is present:
  - How are you holding up?
  - Are you feeling overwhelmed or burnt out?
  - What is the toughest part of this for you?
  - What sorts of things are you doing just for you?

Note: Involving the care partner as an individual early on can build rapport. These questions move beyond "How are you?" to let the care partner know you care about them and will help you help both care partner and patient more fully.

ROS

- ⊗ Change in weight
- ⊗ Change in appetite
- ⊗ Dysphagia for liquids
- ⊗ Skin breakdown/bedsores (only if chair or bedbound)
- ⊗ Recent infections or hospitalizations
- ⊗ Acceleration in loss of function (e.g. ability to do ADLs) or dementia
  1. Personal hygiene
  2. Dressing
  3. Eating
  4. Maintaining continence
  5. Transferring/Mobility
- ⊗ Falls/loss of mobility
- ⊗ Increased sleep (particularly in setting of dementia)

Note: These items cover red flags that may signal a need to consider hospice or specialist palliative care.

- ⊗ Mood (anxiety, depression)
- ⊗ Other challenging emotions (guilt, anger, grief, loneliness, worry, hopelessness)
- ⊗ Nightmares/hallucinations/delusions

Note: These items cover mood and other challenging emotions/spiritual issues.

- ⊗ Pain
  - If present can determine if pain is likely due to PD (e.g. off time, dystonia, dyskinesia, neuropathy, bloating, frozen shoulder) or other issues (e.g. arthritis, migraine, chronic low back pain)
- ⊗ Insomnia/sleep maintenance
- ⊗ Fatigue/daytime sleepiness
- ⊗ Constipation
- ⊗ Bladder urgency
- ⊗ Light-headedness

Note: These items cover non-motor symptoms that are often missed. Please also keep other items that you routinely check.

SocHx

- ⊗ Presence of care partner (if not at visit)
- ⊗ Presence of paid or unpaid help at home (if difficulties with ADLs or mobility)
- ⊗ Status of healthcare proxy and advance directive
- ⊗ Living situation (home, independent-, assisted-, or skilled nursing facility)

Note: Asking about advance directive/proxy during social history normalizes advance care planning as part of routine care and makes it easier to address when you wrap up visit.

Assessment

- ⊗ Prognosis (decades, years, months, weeks, days)
- ⊗ Sources of suffering
- ⊗ Opportunities for joy and meaning

Note: Reminding yourself to consider prognosis may help to refer to hospice or specialist palliative care in a timely fashion. Framing assessment in terms of suffering and joy is a reminder to practice person-centered care and may highlight significant issues that are typically not addressed in biomedical model of care.

Plan

- ⊗ Advance care planning clinic or visit (if needs to be done and anticipate needing more discussion than you have time for)
- ⊗ Social Work referral (if care partner or psychosocial support needed)
- ⊗ Chaplain/counseling (if difficult emotions or spiritual distress)
- ⊗ Pain specialist (if significant pain, especially if falls outside of PD management like BoNT injections)
- ⊗ Specialist palliative care (if significant suffering or additional support needed)
- ⊗ Hospice (if prognosis can be measured in months/if answer to “Would I be surprised if this patient died in next 6 months?” (“surprise question”) is *no*

Note: Not all items detected above need to be addressed by you during this visit. One can be comprehensive but still time-efficient by making appropriate referrals. Regarding advance care planning, this will depend on how your COE chooses to address this issue. Options could include: providing ACP resources and completing at next visit; referral for ACP one-on-one or group visit; referral to other team member to complete ACP.

Return Patient Note Template Checklist

Notes: You can use identical checklist as for new patient visit with following considerations.

HPI

- ⊗ Same as new template but may be briefer. Good to check in with both patient and care partner (if present) with any new concerns.
- ⊗ Consider using flowsheet to pull last date advance care planning was reviewed.

ROS

- ⊗ You may want to consolidate your ROS to focus on issues above and eliminate items (e.g. cardiovascular, pulmonary…) that are not relevant to ongoing care of PD patients