Continuous palliative sedation report form

Patient

Last name

Health insurance number

First name

Record no.

Age

Sex

☐ F ☐ M

1. Institution

Name of the institution (CISSS, CIUSSS, CHU, etc.)

Care setting (check)

☐ Home

☐ Hospice – name

☐ CHSLD[1] – name

☐ CHSGS[2] – name

2. Main diagnosis and clinical condition

1 CHSLD: Residential and long-term care centre.
2 CHSGS: General and specialized hospital centre.

3. Symptoms that warrant considering the use of continuous palliative sedation (check)

- ☐ Hyperactive delirium with uncontrollable psychomotor agitation
- ☐ Major and recurrent respiratory distress
- ☐ Progressive and intractable dyspnea
- ☐ Refractory seizures
- ☐ Intolerable and untreatable pain
- ☐ Copious and refractory bronchial secretions
- ☐ Hemorrhagic distress
- ☐ Intractable nausea and vomiting
- ☐ Refractory psychological or existential distress that severely compromises comfort
- ☐ Other refractory condition – specify

4. Previous therapies tried

Pharmacological

including intermittent sedation ☐ Yes ☐ No

Non-pharmacological

5. Estimated prognosis of survival

Expected duration of continuous sedation (number of days)

6. Administration of continuous palliative sedation

☐ Yes – date and start time

Year | Month | Day | Hour

☐ No – specify

Second opinion requested ☐ Yes ☐ No

7. Written consent obtained

☐ Yes – attach a copy of the consent form (AH-880A-DT-9235)

☐ No – specify

8. Medication prescribed

Medication	Route of administration	Starting dose*	Final dose*
Lorazepam			
Midazolam			
Methotrimeprazine			
Chlorpromazine			
Phenobarbital			
Propofol			
Scopolamine			
Other			

* Quantity of medication per unit of time (e.g., 1 mg/h, 450 mg/24h, 0.4 mg q 4h)

9. Hydration

Natural

☐ discontinued spontaneously by the patient on (date) Year Month Day

☐ discontinued by the physician on (date) Year Month Day

Artificial

☐ discontinued on (date) Year Month Day

10. Nutrition

Natural

☐ discontinued spontaneously by the patient on (date) Year Month Day

☐ discontinued by the physician on (date) Year Month Day

Artificial

☐ discontinued on (date) Year Month Day

11. Course until death

- [ ] Peaceful death
- [ ] Incomplete relief – specify
- [ ] Complications – specify

Confirmation of death on (date)

Year Month Day

12. Attitude of family / health care team throughout the process

	Meeting (date)	Disagreement	Approval	Collaboration
Family				
Health care team				

13. Comments

14. Continuous palliative sedation report form

Completed on (date) Year Month Day

And sent on (date) Year Month Day

- [ ] to the council of physicians, dentists and pharmacists[3]
- [ ] to the Collège des médecins du Québec[4]

15. Physician responsible

Last name

First name

Licence no.

Professional contact information

Correspondence address

Telephone no.

Signature

3 If the physician practices his profession in a centre operated by an institution.
4 If the physician practices in a private health facility.