

ALS Palliative Care Consent Form

Patient Information

Patient Name

Date of Birth

Medical Record Number

Palliative Care Plan Summary

Summary of Care Plan

Discussions

Topics Discussed (select all that apply):

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Goals of Care

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Symptom Management

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Advance Directives

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Other

Consent Confirmation

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I confirm that I have discussed the palliative care plan for ALS, understand the options and have had all my questions answered.

Patient/Legal Representative Name

Relationship (if not patient)

Date

Healthcare Provider Name

Date