Pain Management Palliative Consent Form

Patient Information

Patient Name:

Date of Birth:

Medical Record Number:

Provider Information

Physician/Provider Name:

Date:

Consent

☐ I have been informed about my pain and palliative care treatment, including risks, benefits, and alternatives.

☐ I have had the opportunity to ask questions and they have been answered to my satisfaction.

☐ I understand that participation in this pain management/palliative care plan is voluntary.

Treatment Plan Summary

Summary of Planned Pain Management and Palliative Care:

Signature

Patient/Representative Name:

Relationship to Patient (if Representative):

Date:

Provider Signature

Provider Name:

Date: