Palliative Care Transition Plan

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient ID: [Insert Patient ID]

Address: [Insert Address]

Phone Number: [Insert Phone Number]

Current Medical Condition

[Brief description of the patient's current medical condition and prognosis]

Goals of Care

[Outline the patient's goals of care, including preferences and values]

Plan for Transition to Palliative Care

- Commencement Date: [Insert Date]
- Primary Care Team: [Insert Names and Roles]
- Palliative Care Provider: [Insert Name]
- Location of Care: [Insert Location]

Supportive Services

[List any supportive services required, such as counseling or physical therapy]

Emergency Plan

[Instructions on what to do in case of emergencies]

Follow-Up Appointments

[Details on follow-up appointments and check-ins]

Contact Information

For any questions, please contact:

[Insert Contact Person]

Phone: [Insert Phone Number]

Email: [Insert Email Address]

Thank you for your attention to this transition plan.

Sincerely,

[Your Name]

[Your Position]

[Your Organization]