SAMPLE

Carer Symptom Management Plan

PalliativeCare AUSTRALIA

Child's Name _____

Weight _____ Age _____ Date of Birth _____

ID Numbers (Medicare/hospital) _____

Key Contact (Who to call 24/7): Name _____ Phone No. _____

Allergies	**Diagnosis (if known) or main illness**

Regular Medications

Symptom	Symptom Management (e.g. medication)
eg. Pain	Regular medicine for mild pain: For stronger pain:

Continued over page

Symptom	Symptom Management (e.g. medication)

Additional Notes

Written by _____ Date _____