1. Demographic details (age, sex, ethnic group, social circumstances)
2. Diagnosis
3. Status and staging at the time of referral
4. Date of referral
5. Source of referral
6. Reason for referral
7. Date and place of death (where appropriate)
8. Nature and purpose of contacts and interventions (for the team)
9. Any indication a formal pathway of care was being followed (eg. Liverpool Care Pathway)
10. Presence of a record of discussion regarding patient's concerns/choices in end of life care
11. Any statement of preferences/values regarding place/style of care, and related outcomes at end of life.
12. 'Do Not Resuscitate' orders (or similar) and proximity to death
13. Indicators of symptom/pain control, psychosocial and spiritual support (including family care)