

GUIDE FOR PATIENT AND FAMILY DECISION-MAKING

<p>This form is designed to help patients and family members discuss medical indications and treatment options with members of the healthcare team. A signed copy of this form should be given to the patient or family member(s) and should also be included in the patient's chart.</p>	Last Name of Patient	
	First Name/Middle Initial of Patient	
	Patient Date of Birth (mm/dd/yy)	
SECTION A	What is the patient's diagnosis?	What interventions are recommended?
SECTION B CHECK ALL THAT APPLY	<p>Areas discussed with patient/family:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> pt/family understand diagnosis <input type="checkbox"/> pt/family understand treatment <input type="checkbox"/> pt/family understand choices <input type="checkbox"/> consequences of accepting/refusing therapy <input type="checkbox"/> concerns about coercion, duress, abandonment, or capacity </div> <div style="width: 45%;"> <input type="checkbox"/> advance directives/DNR <input type="checkbox"/> financial issues <input type="checkbox"/> life expectancy <input type="checkbox"/> potential disability/suffering <input type="checkbox"/> interpreter needed <input type="checkbox"/> pt/family advised about who to ask for information (see other side) </div> </div>	
SECTION C CHECK ALL THAT APPLY	<p>Who agrees with the care plan?</p> <input type="checkbox"/> doctor <input type="checkbox"/> nurse <input type="checkbox"/> family <input type="checkbox"/> administration <input type="checkbox"/> patient <input type="checkbox"/> other	<p>Who has authority to make decisions?</p> <input type="checkbox"/> does physician have authority to make decision for pt. <input type="checkbox"/> does pt have authority to refuse or demand care <input type="checkbox"/> does family have authority to refuse or demand care <input type="checkbox"/> authority lies with other agent or surrogate
SECTION D CHECK ALL THAT APPLY	<p>Areas of possible concern:</p> <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input type="checkbox"/> professional codes <input type="checkbox"/> standard of care <input type="checkbox"/> futility/utility <input type="checkbox"/> efficacy/inefficacy <input type="checkbox"/> privacy </div> <div style="width: 30%;"> <input type="checkbox"/> interests/rights of other <input type="checkbox"/> diagnosis & prognosis <input type="checkbox"/> protection of others <input type="checkbox"/> legal obligations <input type="checkbox"/> quality of life </div> <div style="width: 30%;"> <input type="checkbox"/> communication with family/pt <input type="checkbox"/> awareness of community norms <input type="checkbox"/> reporting of errors <input type="checkbox"/> referral to social services </div> </div>	
SECTION E CHECK ALL THAT APPLY	<p>Goals of therapy:</p> <input type="checkbox"/> Should resuscitation be attempted? <input type="checkbox"/> Shall artificial nutrition and hydration be utilized? <input type="checkbox"/> Should a nursing home resident or someone ill at home be hospitalized? <input type="checkbox"/> Is it time to reconsider treatment goals?	
SECTION F CHECK ALL THAT APPLY	<p>Discussed with:</p> <input type="checkbox"/> Patient <input type="checkbox"/> Parent of minor <input type="checkbox"/> Healthcare representative <input type="checkbox"/> Court-appointed guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<p>Patient signature:</p> <p>_____ Date: _____</p> <p>Healthcare provider signature:</p> <p>_____ Date: _____</p>

FORM FOR ASSESSMENT OF ETHICAL ISSUES IN PATIENT CARE

SECTION G	Issues that may need further attention:	Recommendations:		
SECTION H	Please review this form if there is a substantial change in patient's health status such as: <input type="checkbox"/> Close to death <input type="checkbox"/> Improved condition <input type="checkbox"/> Advanced progressive illness <input type="checkbox"/> Extraordinary suffering <input type="checkbox"/> Transfer <input type="checkbox"/> Permanent unconsciousness			
SECTION I	Review of this form			
	Date of review	Reviewer	Location of review	Outcome of review
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided: new form <input type="checkbox"/> Form voided: no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided: new form <input type="checkbox"/> Form voided: no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided: new form <input type="checkbox"/> Form voided: no new form
				<input type="checkbox"/> No change <input type="checkbox"/> Form voided: new form <input type="checkbox"/> Form voided: no new form

If you have questions about the information we have discussed, you may contact:

Name: _____

Phone Number: _____

Name: _____

Phone Number _____