fraserhealth

ADVANCE CARE PLANNING (ACP) RECORD

ACP, SERIOUS ILLNESS & GOALS OF CARE CONVERSATIONS
This is a reference and may not reflect most up to date conversations.

Mary Jones
Age: 71

Tools to facilitate ACP conversations:
- FH Core Elements
- Serious Illness Conversation Guide (SICG)
- Goals of Care

Select most appropriate tool based on purpose of conversation, acuity/prognosis of illness, and/or treatment decision making.
See back for further details.

Previous Advance Care Planning documentation: Reviewed and copy in Greensleeve (if applicable):

☐ Advance Care Planning Record ☐ Advance Care Plan
☐ Representation Agreement ☐ Advance Directive
☐ Provincial No CPR
☐ Medical Orders for Scope of Treatment (MOST)

Type of conversation and tool utilized. (check one)	Brief summary of key outcomes/decisions of conversation.	Recommendations/Next Steps
✓ FH Core Elements ☐ Serious Illness Conversation Guide (SICG) ☐ Goals of Care (GoC)	S – Rep 9 completed. Husband appointed. P – clt prefers to hear all medical information at once to process. E – clt has not made any treatment specific decisions. A – no Advance Directive K – clt and husband seem to have limited understanding of illness and illness trajectory. Client identified that social interactions with friends and her ability to engage with spouse were most important to her. Worries about feeling short of breath. Detailed Notes can be found: Dated:	Next steps *patient/client/resident/SDM* responsible for (eg. learn about illness, talk to family, legal/financial planning): Requested clt bring Rep Agreement to next visit Next steps *recorder/HCP* responsible for: 1) Recommend review of discussion with: Arrange meeting with clt, husband, ? family, cardiologist. 2)

Date (dd/mm/yyyy)	Name & discipline of recorder; participants & relationship:	Site/Location:	Signature
12/09/2018	J Bell, SW; client and husband	JP HFC	J Bell, SW

ACP Records completed in non-acute settings please fax to 604-587-3748