

Universal Form of Treatment Options

For staff use only:

Hospital no:

Surname:

First names:

Date of birth:

NHS No. ____/____/____

(Use hospital identification label)

Relevant information about patient's situation:

Please write details of discussion (and/or reasons for not having one, if none has taken place) overleaf:

This patient is for the following treatment plan: (please sign one of the below boxes, complete the resuscitation box, and sign and date)

ACTIVE TREATMENT

e.g. investigations, surgical and medical interventions and treatments, referral to on-call doctors or outreach in event of deterioration

Signature..... Date DD/MM/YYYY

OPTIMAL SUPPORTIVE CARE

e.g. analgesia and other comfort measures. This includes minimally invasive treatments (such as paracentesis) to improve symptom control/quality of life. **The patient's comfort should be the priority in determining care.** Please document future care planning on reverse.

Signature..... Date DD/MM/YYYY

Active Treatment usually includes:

Organ Support or High Dependency Unit if needed and appropriate (NIV, dialysis, inotropes, venous monitoring, cardioversion, etc.) and **Intensive care** if needed and appropriate (intubation and ventilation, support of multi-organ failure, etc)

If you wish to provide guidance on specific interventions please do so below:

This patient is **FOR attempted**
CARDIOPULMONARY RESUSCITATION
in the event of a cardiac arrest

Signature.....

This patient is **NOT FOR attempted**
CARDIOPULMONARY RESUSCITATION
in the event of a cardiac arrest

Signature.....

This form is for review: NO / YES, at the following frequency:

Print Name	Signature	Date and Time	Contact No.	Designation
				ST3 or above
				Consultant
				Nurse Informed

Does the Patient have the **mental capacity** to be involved in decisions regarding treatment escalation and CPR? **Yes** ☐ **No** ☐

if 'No' : Decisions regarding treatment/CPR must be made following Best interest principles of the Mental Capacity Act 2005

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Documentation of Discussions

These decisions HAVE been discussed with patient/relatives/partner/IMCA (give brief overview of discussion)

These decisions have NOT BEEN discussed with the above for the following reasons

Please record date and time when discussion has taken place:

FUTURE CARE PLANNING:

Many patients wish to be involved in advance care planning, so that their wishes can still be acted upon should they lose decision-making capacity in the future. Please offer patients and families the opportunity to discuss the following and document below:

- **Understanding of disease and prognosis**
- **Important values and goals of care**
- **Preferences for future place of care and potential treatments**

This may be useful for any patient, but is particularly important in those with incurable or progressive disease. Attach relevant documents where necessary.

Print name, signature, designation and date and time
(clinical team, patients, relatives and/or lasting powers of attorney may write if they wish)

Does patient require Community DNACPR form on discharge? Yes ☐ No ☐

Note: this form may be temporarily revoked in context of a procedure which may induce cardiac arrest- e.g. cardiac pacing/angiogram/surgical intervention

Instructions for REVIEW: If the patient's situation changes a new form can be completed and this form should have a line put through it and be filed in the patient's notes.

Date: 24.2.14. Version: 22

Dept: Acute Medicine, Ext 4597, Box 148

Please file behind ALERT sheet when active, and within clinical notes once cancelled

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