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.**	