Winnipeg Regional Health Authority / Office régional de la santé de Winnipeg
Caring for Health / À l'écoute de notre santé

ADVANCE CARE PLANNING GOALS OF CARE

Refer to WRHA Advance Care Planning Policy # 110.000.200 prior to completing this form

Is there an existing Health Care Directive? ☐ No ☐ Yes
(If yes, it shall guide further discussions as an indication of the Patient/Client/Resident's wishes at the time of writing)

Advance Care Planning (ACP) is the overall process of dialogue, knowledge sharing and informed decision making that needs to occur at any time when future or potential life threatening illness treatment options and Goals of Care are being considered or revisited. This form is used to record agreed upon Goals of Care reached through full and complete ACP discussions with the Patient/Resident/Client and/or Substitute Decision Maker about the nature of the individual's current condition, prognosis, treatment/procedural/investigation options, and expected benefits or burdens of those options.

GOALS OF CARE (Check the box that best describes the Patient/Resident/Client Goals of Care)

☐ **C = Comfort Care** - Goals of Care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life ***excluding*** attempted resuscitation.

☐ **M = Medical Care** - Goals of Care and interventions are for care and control of the Patient/Resident/Client condition. The Consensus is that the Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/ interventions that can be offered ***excluding*** attempted resuscitation.

☐ **R = Resuscitation** – Goals of Care and interventions are for care and control of the Patient/Resident/Client condition. The Consensus is that the Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/ interventions that can be offered ***including*** attempted resuscitation.

If the required care is not available in current location or setting, does the Patient/Resident/Client want to be transferred to alternate facility? ☐ No ☐ Yes

Indicate all individuals who participated in Goals of Care discussion(s) by checking appropriate box(es).

☐ Patient/Resident/Client Print Name: _____

☐ Family Member(s) Print Name(s): _____

☐ Substitute Decision Maker Print Name(s): _____

☐ Health Care Provider(s) Print Name(s): _____

Document details of the Patient/Resident/Client specific instructions or wishes and/or details of discussion with the individuals indicated above. (Refer to date/time of Progress Note entry if more space is required):

_____

_____

_____

_____

_____

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y YA

The Goals of Care were reviewed with the Patient/Resident/Client and/or Substitute Decision Maker and no change to the form is required.

Name & Designation of Health Care Provider | Signature of Health Care Provider (Physician's signature is required when patient is a client of the Public Trustee) | D D M M M Y Y Y Y

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If review results in any changes to the Patient/Resident/Client Goals of Care, a new form must be completed.

PROVIDE COPY OF COMPLETED FORM TO PATIENT/RESIDENT/CLIENT OR SUBSTITUTE DECISION MAKER