PATIENT-CENTERED PRIORITIES AND GOALS OF CARE (GOC)

❑ **NO KNOWN PREVIOUS GOC/LEVEL OF INTERVENTION (LOI) DECISION**

❑ **REPLACES GOC/LOI COMPLETED (YYYY/MON/DD):** ____________________

PURPOSE: ❑ Future planning ❑ Current or new medical condition ❑ Admission ❑ Other: ____________________

CAPACITY FOR MAKING THIS LOI DECISION (at cognitive baseline; no delirium; understands medical situation)

Patient demonstrates capacity for this LOI decision: ❑ Yes ❑ No	❑ Delegate named in Personal Directive ❑ SDM as per patient ❑ SDM as per hierarchy Name: ____________________ Relationship: ____________________

PRESENT DURING GOC DISCUSSION: ❑ Patient ❑ SDM ❑ Other(s): ____________________

❑ **SEE PAGE 2 for additional information**

PATIENT PRIORITIES (e.g. REMAIN AT HOME, SYMPTOM CONTROL) **OR OTHER DETAILS INFORMING LOI:**

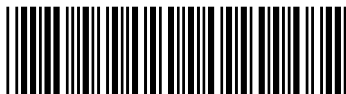
LOI DECISION MADE AFTER CONVERSATION BETWEEN PATIENT AND/OR SDM AND AUTHORIZED HEALTH CARE PROVIDER (AHCP) AND/OR MOST RESPONSIBLE HEALTH CARE PROVIDER/AUTHORIZED PRESCRIBER (MRHCP/AP)

Focus of Care	Supportive care, symptom management and comfort measures within current location of care if possible. Allow for natural death.		Medical treatment to cure or control symptoms and prolong life, excluding CPR. Allow for natural death.		Preserve/prolong life by all medically effective means.
Type of Care and Level of Intervention:	**COMFORT CARE**		**SELECTIVE CARE**		**FULL CODE**
	❑ **C2**	❑ **C1**	❑ **S2**	❑ **S1**	❑ **F**
Patient's perspective	"Keep me comfortable and do not delay my death"	"I accept treatments but not at the expense of my immediate comfort"	"Do as much as possible but I do not want life support"	"Do everything until the point of my natural death"	"Do everything possible to save my life, even if it causes discomfort"
Care and treatment targeted to symptoms	✓	✓	✓	If possible	If possible
Treatment which may prolong life	X	Decided in real time based on context and priorities	✓	✓	✓
Transfer to acute care facility	Decided in real time based on context and priorities	Decided in real time based on context and priorities	✓	✓	✓
Non-invasive positive pressure ventilation and/or vasopressors	X	X	Decided in real time based on context and priorities	✓	✓
Intubation (outside surgery)	X	X	X	✓	✓
Full Resuscitation (CPR)	X	X	X	X	✓

Copy to: ❑ Primary Care Provider ❑ LTC Facility ❑ Continuing Care ❑ Patient/SDM ❑ Other: ____________________

AHCP conducting discussion (Print Name)	AHCP conducting discussion (Signature)	Date (YYYY/MON/DD)	Time (HH:MM)
MRHCP/AP (Print Name)	MRHCP/AP (Signature)	Date (YYYY/MON/DD)	Time (HH:MM)

*****FAX BOTH SIDES OF COMPLETED FORM to Health Information Services' centralized office for processing.
FAX NUMBER: 902-473-4999*****



PATIENT-CENTERED PRIORITIES AND GOALS OF CARE (GOC)

GOALS OF CARE SUPPLEMENTARY INFORMATION (OPTIONAL)

In discussing levels of intervention/goals of care with this patient/delegate, I have taken into consideration the following:

The presence of the following serious, chronic life limiting conditions, and their cumulative effect on physical and cognitive function (check all that apply):

- ❑ Cancer (not responding to treatment or too frail for treatment)
- ❑ Dementia
- ❑ Severe chronic lung disease with significant breathlessness and/or need for oxygen
- ❑ Congestive heart failure or extensive untreatable coronary artery disease
- ❑ Severe/inoperable peripheral vascular disease
- ❑ Kidney disease (eGFR less than 30 mL/min)
- ❑ Decompensated cirrhosis
- ❑ Neurological disease associated with significant loss of function/recurrent aspiration/deterioration of physical/cognitive function
- ❑ Other: ____________________

❑ New acute/potentially treatable conditions: ____________________

In the past 12 months:

❑ Number of unplanned healthcare interactions (ED visits/admissions): ____________________

❑ Changes in ability to ambulate: ____________________

❑ Sources of joy and quality of life: ____________________

❑ Burden of uncontrolled symptoms: ____________________

❑ Increasing dependence on others in the community (note changes and timelines): ____________________

❑ Sustainability of preferred living arrangements and care: ____________________

OTHER CONSIDERATIONS THAT IMPACTED THE DISCUSSION

MORE INFORMATION CAN BE FOUND IN PATIENT'S MEDICAL RECORD LOCATED IN: ____________________

If supplementary information above is completed, sign and date below.

AHCP conducting discussion (Print Name)	AHCP conducting discussion (Signature)	Date (YYYY/MON/DD)	Time (HH:MM)
MRHCP/AP (Print Name)	MRHCP/AP (Signature)	Date (YYYY/MON/DD)	Time (HH:MM)

*Scan to see the Goals of Care Library Guide and tips on how to complete this form.