5-Hole 1/4 1 3/8 c-to-c

Date of Service: _____ Time of Service: _____
Attending Provider: _____ Primary Service: _____
Purpose: ☐ Information sharing ☐ Goal setting ☐ End of Life planning ☐ Follow-up to prior meeting (date _____)
Decision Maker: ☐ Patient ☐ POAHC ☐ Family Consensus ☐ Guardian
Participants: Meeting Leader: _____
☐ Patient ☐ POAHC Family: _____
Medical Team: _____
Nurse(s): _____ Social Worker: _____
Case Manager: _____ Chaplain: _____
Palliative Care Team: _____
Other: _____
Diagnosis: _____
Current Complications: ☐ Aspiration ☐ Cognitive Failure ☐ CVA ☐ Failure to thrive/weight loss ☐ Gangrene
☐ Hypotension ☐ Liver Failure ☐ PE ☐ Pneumonia ☐ Renal Failure ☐ Sepsis
Other: _____
Prognosis: ☐ Gradual improvement ☐ Continued complications: _____
Estimated Time for Recovery: ☐ Days - Weeks ☐ Weeks - Months ☐ Less than 1 year ☐ Depends upon goals ☐ Unknown
Estimated Length of Life: ☐ Days - Weeks ☐ Weeks - Months ☐ Less than 1 year ☐ Depends upon goals ☐ Unknown
☐ Death likely during this hospitalization despite aggressive care
☐ Other: _____
Process: The current medical information including test results, the various treatment options, risks/benefits/alternatives were reviewed. The family had an opportunity to ask questions.
Comments: _____
_____
_____
_____
Patient/Family Goals: ☐ Prolong life ☐ Return to home ☐ Comfort ☐ Upcoming important event: _____
☐ Other: _____
Decisions: ☐ Continue all efforts to prolong life ☐ Continue limited support: specify _____
☐ Withdraw current support and focus solely on comfort, with death as the expected outcome.
☐ DNR ☐ PEG placement ☐ Trach placement
Request Chaplain Visit: ☐ Yes ☐ No
☐ Hospice Referral ☐ Transfer to: _____
☐ Family Consensus ☐ Unable to obtain Family Consensus ☐ No decisions made. Follow up: _____
☐ Other: _____
Next Meeting: ☐ No ☐ Yes Date: _____ Time: _____

All 4 elements within this box must be completed
Provider Signature: _____ Provider #: _____ Date: _____ Time: _____

Faculty Attestation (Summary of conference discussion): _____
_____
_____
_____ Total time spent in family conference: _____

All 4 elements within this box must be completed
Provider Signature: _____ Provider #: _____ Date: _____ Time: _____

Care Team Participants Signatures:

_____ _____
_____ _____
_____ _____
_____ _____

Family Conference Note
50476

ORIGINAL - Medical Records

Froedtert HOSPITAL
Froedtert & Community Health
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61210
07/08

Family Conference Note - Item # 50476