EMR000040

_____ Health Service **Residential Goals of Care** GP / Doctor: _____	Surname	UMRN / MRN	
	Given Name	DOB	Gender
	Address		Post Code
		Telephone	

Please complete this form in discussion with the person (resident), person responsible, appointed guardian(s) and / or family / carer(s), and refer to any advance care planning (ACP) documents.

The form helps establish the most appropriate, agreed-upon goal of care that will apply in the event of the person's deterioration, in line with their preferences and priorities of care. The form is complementary to ACP but does not replace Advance Health Directives (AHD) and Enduring Powers of Guardianship (EPG).

Refer to organisation guidelines or instructions for further information about using the form.

SECTION 1: BASELINE INFORMATION Current health, illnesses and / or significant co-morbidities:

In the event that the person is unable to speak for themselves, who would they wish to speak for them?

'Person responsible' name:_____

Relationship: _____ Phone: _____

Interpreter required: ☐ Yes ☐ No Languages: _____

Does the person have the following document(s)? (*also check My Health Record and local digital records*)

- Advance Health Directive (AHD) ☐ Yes ☐ No If yes, copy in file? ☐ Yes
- Values & Preferences Form / Advance Care Plan ☐ Yes ☐ No If yes, copy in file? ☐ Yes
- Advance care plan for a person with insufficient decision-making capacity ☐ Yes ☐ No If yes, copy in file? ☐ Yes
- Is there an appointed guardian for this person? ☐ Yes ☐ No

If 'Yes', indicate guardianship type: ☐ EPG ☐ SAT appointed ☐ Public Advocate

Appointed guardian name: _____ Phone:_____

SECTION 2: SUMMARY OF DISCUSSION(S), PREFERENCES AND PRIORITIES OF CARE

Complete in discussion with the person / person responsible. Refer to any ACP documents above.

What matters most to the person in relation to:

- Values & wishes, physical, cultural, spiritual & environmental needs? (*include end of life preferences*).
- Medical & life sustaining treatments, transfers & hospitalisations? (*discuss what can be provided at site*)
- Treatments or situations that are undesirable / unwanted? *(include regional / metro hospital preferences*)

Preferred place for end-of-life care: _____

Location of end of life requests / funeral information (if applicable): _____

_____ Health Service

Residential Goals of Care

GP / Doctor: _____

Surname	UMRN / MRN	
Given Name	DOB	Gender
Address		Post Code
	Telephone	

SECTION 3: GOAL OF CARE (**Tick only one** and complete Section 4 below to be valid).

Select the most medically appropriate goal of care that aligns with the person's preferences for care (as outlined in Section 2), that will apply in the event of the person's condition deteriorating. **This is subject to clinical judgement at the time of proposed treatment, to ensure the treatment is in the person's best interest.**

☐ **All Life Sustaining Treatment including CPR**

*Transfer to hospital (including metropolitan hospitals) if required treatment cannot be provided in facility.

☐ **Life Extending Treatment with treatment ceiling**

*Specify maximum level of support that can be provided in facility before transfer to hospital is required:

Not for CPR

_____

_____

_____

☐ **Optimal Comfort Treatment**

Not for CPR
Not for intubation
Not for ICU
Not for hospital transfer unless measures fail to maintain comfort & dignity at facility

*Active symptom and comfort care including:

_____

_____

_____

** Consider referral to specialist palliative care team / clinician

SECTION 4: DISCUSSION(S) AND REVIEW

Was the person able to participate in the discussion(s)? ☐ Yes ☐ No (*if 'No' reason MUST be included*)

If 'No', comment :_____

Name(s) of people involved in discussion(s): _____

_____

Optional for person / person responsible to sign below to acknowledge the purpose of the form was explained and they are aware they can revisit or revoke the form at any time. A copy can be provided on request.

Goal of care explained to: ☐ Person ☐ Person responsible ☐ Other: _____

Name: _____ Signature: _____ Date: ___ / ____ / ____

Clinician completing form (name): _____ Designation: _____

Signature: _____ Date: ____/____/____ Time: _____

Validating Doctor / Nurse Practitioner (name): _____ Designation: _____

Signature: _____ Date: ____/____/____ Time: _____

☐ Valid for up to 12 months OR until: _____ / _____ / _____ (maximum 12 months)

☐ **Yes to MHR upload** (tick <u>if person provided instruction</u> to upload copy of form to their My Health Record)

REVIEW BY DOCTOR / NURSE PRACTITIONER (at 12 months or earlier if indicated)

Review date: ____/____/___ Goal of Care unchanged: ☐ Yes (sign below) ☐ No (complete new form)

Name: _____ Designation: _____

Signature: _____ Date: ____/____/_____ Time: _____

☐ Valid for a further 12 months OR until: _____ / _____ / _____ (maximum 12 months)

☐ **Yes to MHR upload** (tick <u>if person provided instruction</u> to upload copy of form to their My Health Record)

Once validated, extends to transfer between facilities / hospital (provide copy during transfers)