Advance Care Planning Tracking Form

INTERACT®
Version 4.0 Tool *

Resident Name _____

Residents and/or their responsible health care decision makers should be provided the opportunity to discuss advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans. The purpose of this tool is to document these discussions. (Several other INTERACT Advanced Care Planning Tools may be helpful in ACP discussion)

This documentation is to

☐ Create a new Advance Care Plan ☐ Review existing Advance Care Plan

Reason for this discussion/review

☐ Admission ☐ Change in condition alert ☐ Other
☐ Readmission ☐ Resident or Family Request

This discussion was held with

☐ Resident ☐ Resident's surrogate Name_____

Was an Advance Care Plan created or change made, as a result of this discussion?

☐ No
☐ Resident declined conversation ☐ Resident/surrogate not available at this time
☐ Surrogate declined conversation

☐ Yes

Describe the Key Aspects of the discussion _____
_____
_____
_____
_____

Advance Directive Orders in Place**
(Any change in Advance Directives needs an order signed by the physician per your state requirements)
Check all that apply

☐ Full Code ☐ DNR ☐ No Artificial Feeding
☐ DNI ☐ POLST/MOLST/POST
☐ DNH ☐ Other Care Limiting Orders

Is the resident on

☐ Comfort Care/Palliative Care Plan
☐ Hospice

Staff or healthcare provide leading discussion:

Name _____ Title _____

Signature _____ Date of discussion _____/_____/_____

©2014 Florida Atlantic University, all rights reserved. This document is available for clinical use, but may not be resold or incorporated in software without permission of Florida Atlantic University.