Advance Care Planning Tracking Form

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    ☐ DNH    ☐ POLST/MOLST/POST
☐ DNH    ☐ No Artificial Feeding

Is the resident on
☐ Comfort Care/Palliative Care Plan
☐ Hospice

Staff or healthcare provide leading discussion:

Name ____________________________________________________________    Title __________________________

Signature ____________________________ Date of discussion _______/ _______/ _______