Health PEI
One Island Health System

GOALS OF CARE

Is there an existing Health Care Directive on file? ☐ No ☐ Yes
(If yes, it shall guide further discussions as an indication of the Patient/Client/Resident's wishes at time of writing)

GOALS OF CARE	Initials of Health Care Provider	
R **Medical Care and Interventions, including Resuscitation**		Goals of care and interventions are for care and control of the Patient/Resident/Client condition. The Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered ***including resuscitation*.**
M **Medical Care and Interventions, excluding Resuscitation**		Goals of care and interventions are for care and control of the Patient/Resident/Client condition. The Patient/Resident/Client may benefit from, and is accepting of, any appropriate investigations/interventions that can be offered ***excluding resuscitation*.**
C **Care and Interventions focused on comfort, excluding Resuscitation**		Goals of care and interventions are directed at maximal comfort, symptom control and maintenance of quality of life, ***excluding resuscitation*.**

If the Goals of Care indicated above include resuscitation, indicate below which interventions the Patient/Resident/Client is accepting of:
(a) defibrillation ☐ (b) chest compressions ☐ (c) intubation ☐ (d) ICU/CCU care ☐
(e) ICU/CCU care for noninvasive ventilation and treatment ☐

Indicate all individuals who participated in Goals of Care discussion(s) by checking appropriate box(es).
☐ Patient/Resident/Client Print Name: _____
☐ Family Member(s) Print Name: _____
☐ Substitute Decision Maker Print Name: _____
☐ Health Care Provider(s) Print Name: _____

Document details of the Patient/Resident/Client specific instructions or wishes and/or details of discussions with the individuals indicated above on back of page.

I confirm that I have discussed my Goals of Care with a Health Care Team member and that this form accurately reflects the choice(s) that I have made respecting the type of care I want to receive. I understand that this document is a record of my conversation with the Health Care Team and not a health care directive as defined under the *Consent to Treatment and Health Care Directives Act*.

_____ _____
Signature of patient/resident/client/substitute decision maker **yyyy/mm/dd**

_____ _____ _____
Name and Designation of RN, NP or MD **Signature of RN, NP or MD** **yyyy/mm/dd**

The Goals of Care were reviewed with the Patient/Resident/Client and/or Substitute Decision Maker and no change to the form is required.

_____ _____ _____
Name and Designation of RN, NP or MD **Signature of RN, NP or MD** **yyyy/mm/dd**

If review results in any changes to the Patient/Resident/Client Goals of Care, a new form must be completed.

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Refer to date/time of Progress Note entry if more space is required.