

Affix patient sticker here

Hospital admission date:

Date of assessment:

Time of assessment:

Assessment number *(for repeat assessments)*

Critical Care: Decision-support Form

This form can be used to guide and record the decision-making process regarding the critical care support a critically ill patient should receive. It is designed to support best practice in decision-making.

Evidence: Clinical *(factors in patient's acute condition and long term health relevant to decision about escalating treatment)*

Evidence: Ability to recover from this critical illness based on evidence *(e.g: functional reserve, trajectory of illness, exercise capacity, dependence, self-reported QoL, frailty score)*

Evidence: Patient values and wishes *(what is important to the patient with regard to their treatment and the potential out-comes? Please note ReSPECT form/advance decision to refuse treatment if available.) If no information is available please say why.*

Please document source of this information: (patient, family or someone close to patient, advance care plan etc)

Balancing burdens and benefits of escalating treatment (based on the evidence in section one)

Benefits of intensive escalation of treatment for this patient (what good may be achieved and what harms avoided?)

How likely is this?)

Burdens of intensive escalation of care for this patient (what harms are likely to occur due to escalating care)

Recommended treatment (summary of goals and focus of care, and actual therapy patient is to receive)

Can this care safely be delivered outside ICU/HDU?

- Care required can only be delivered on ICU/HDU
- Care required can be delivered outside ICU/HDU and resources are available to do this safely
- Care required could be delivered outside ICU/HDU but

Arrangements for ongoing care/review

- Patient will be admitted to ICU/HDU.
- Patient to stay on ward with ongoing ICU or critical care outreach review.
- Patient to stay on ward. If patient's condition changes

Individuals contributing to decision-making

Patient (please state if no involvement and reason for this): _____

Person close to patient: _____

Name: _____

Relationship to patient: _____

Nature of involvement: _____

ICU team

Name: _____ Signature: _____

Role: _____ GMC number: _____

Referring team

Name: _____ Signature: _____

Further information available: see notes entry dated: _____