Affix patient sticl‹er here

Hospital admission date:

Date of assessment:

Time of assessment:

**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**

## Acute presentation:

## Past Medical History:

**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)*

Trajectory of illness:

Clinical Frailty Score:

**Evidence of discussion with patient and next-of-kin (if possible)**

**Ensure a RESPECT form is completed**

**Balancing burdens and benefits of escalating treatment**

Do the burdens of intensive care escalation outweigh the benefits for this patient?

 Yes

 No

Explanation (if required)

**Recommended treatment**

 For active treatment and admission to the intensive care unit

 For active treatment on the ward, with escalation to ICU if deteriorates.

 For active treatment with ceiling of ward-based care. DNACPR. If deteriorates for end-of-life care.

 Not a candidate for active treatment. DNACPR. If deteriorates for end-of-life care.

**Individuals contributing to decision**

 Consultant

Name and GMC no : Signature:

Senior Clinical Decision Maker 2 if necessary (including telephone discussion)

Name: Signature (if available):

Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Senior Clinical Decision Maker 3 if necessary (including telephone discussion)

 Name: Signature (if available):

Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_