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)

<table>
<thead>
<tr>
<th>GOALS OF CARE</th>
<th>Initials of Health Care Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Medical Care and Interventions, including Resuscitation</td>
</tr>
<tr>
<td>M</td>
<td>Medical Care and Interventions, excluding Resuscitation</td>
</tr>
<tr>
<td>C</td>
<td>Care and Interventions focused on comfort, excluding Resuscitation</td>
</tr>
</tbody>
</table>

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.