

NHS No:
Surname:
First Name(s):
D.O.B: / / Gender: M / F
Address:

Somerset Treatment Escalation Plan & Resuscitation Decision

This form represents clinical decisions regarding appropriate medical treatments which have been made with patient/carer involvement as far as possible.

'What is important to me?'

If I am unable to speak for myself please contact	name:
who is my:	on phone number:

Do not attempt CPR For a natural and dignified death <input type="checkbox"/>	Do attempt cardiopulmonary resuscitation (CPR) <input type="checkbox"/>
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If this person is not to have CPR attempted please document rationale:

If a treatment decision is unclear at the time the form is being completed, please tick unclear (see below)

For hospital transfer <input type="checkbox"/>	Life prolonging treatment Referral to critical care is appropriate <input type="checkbox"/>	Non-invasive Ventilation Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/>
Consider hospital transfer Please state conditions overleaf <input type="checkbox"/>	Life prolonging treatment without referral to critical care <input type="checkbox"/>	IV fluids Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/>
Not for hospital transfer unless unmanageable symptoms or emergency e.g. fall, fracture <input type="checkbox"/>	May be for life prolonging treatment <input type="checkbox"/>	IV antibiotics Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/>
	Not for life prolonging treatment Focus on quality of life <input type="checkbox"/>	Oral antibiotics for treatment Yes <input type="checkbox"/> No <input type="checkbox"/> Unclear <input type="checkbox"/>
	Likely to be in the last days of life <input type="checkbox"/>	Symptom control <input type="checkbox"/> For all

Names and roles/relationships of those involved in discussions. Please specify if any of these people hold lasting power of attorney				
Doctor, practitioner or senior nurse endorsing form signature				
Full name	Grade	Date	/ / 20	

