

Date of Service: _____ Time of Service: _____
 Attending Provider: _____ Primary Service: _____
Purpose: Information sharing Goal setting End of Life planning Follow-up to prior meeting (date _____)
Decision Maker: Patient POAHC Family Consensus Guardian
Participants: Meeting Leader: _____
 Patient POAHC Family: _____
 Medical Team: _____
 Nurse(s): _____ Social Worker: _____
 Case Manager: _____ Chaplain: _____
 Palliative Care Team: _____
 Other: _____

Diagnosis: _____
Current Complications: Aspiration Cognitive Failure CVA Failure to thrive/weight loss Gangrene
 Hypotension Liver Failure PE Pneumonia Renal Failure Sepsis
 Other: _____

Prognosis: Gradual improvement Continued complications: _____
 Estimated Time for Recovery: Days - Weeks Weeks - Months Less than 1 year Depends upon goals Unknown
 Estimated Length of Life: Days - Weeks Weeks - Months Less than 1 year Depends upon goals Unknown
 Death likely during this hospitalization despite aggressive care
 Other: _____

Process: The current medical information including test results, the various treatment options, risks/benefits/alternatives were reviewed. The family had an opportunity to ask questions.
 Comments: _____

Patient/Family Goals: Prolong life Return to home Comfort Upcoming important event: _____
 Other: _____

Decisions: Continue all efforts to prolong life Continue limited support: specify _____
 Withdraw current support and focus solely on comfort, with death as the expected outcome.
 DNR PEG placement Trach placement
 Request Chaplain Visit: Yes No
 Hospice Referral Transfer to: _____
 Family Consensus Unable to obtain Family Consensus No decisions made. Follow up: _____
 Other: _____

Next Meeting: No Yes Date: _____ Time: _____

All 4 elements within this box must be completed
Provider Signature: _____ Provider #: _____ Date: _____ Time: _____

Faculty Attestation (Summary of conference discussion): _____

 _____ Total time spent in family conference: _____

All 4 elements within this box must be completed
Provider Signature: _____ Provider #: _____ Date: _____ Time: _____

Care Team Participants Signatures:

Family Conference Note



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Froedtert HOSPITAL
Froedtert & Community Health

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