FAMILY COUNSELLING FORM

Pre-admission level of function/QOL: MRC/NYHA score: ________________________________

Working Diagnosis: __________________________________________________________________

Complications: _____________________________________________________________________

Co-morbidities: ____________________________________________________________________

Method of discussion: Telephonic ☐ In person ☐

Reason for discussion: Collateral history ☐ Decision making ☐ Update on patient condition ☐
EOL/non-beneficial care discussion ☐

Date: ........../........./.............. Time at start: .......... : ............ Time at completion: .......... : ............

Is patient present during discussion?: Yes ☐ No ☐

If no, why?: Intubated ☐ Unconscious ☐ Unable to leave ICU care ☐ Low GCS ☐
Unable to comprehend discussion (confusion/delirium/psychosis/dementia) ☐ Other ☐

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<tr>
<th>Name of family member in attendance</th>
<th>Contact number</th>
<th>Relationship</th>
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Contact details and contact no. of persons (agreed on by family) to act as liaison for further communications:

Name: __________________________________________ Contact no.: ________________________________

Name: __________________________________________ Contact no.: ________________________________

NOTES OF MEETING: _______________________________________________________________________

Name of attending doctor: ________________________ Signature: ________________________________

Name of attending registered nurse: ________________________ Signature: __________________________

Other HCPs present in meeting: Yes ☐ No ☐

If yes,
1. Name: ____________________ FOM: ____________________ Signature: ________________________
2. Name: ____________________ FOM: ____________________ Signature: ________________________

Translator required?: Yes ☐ No ☐ Language used: ________________________________

Name of translator: ________________________ Position: ________________________ Signature: ________________________