Advance Care Planning Assessment
Fax form to: 888.647.6152

Priority Health

Reset Form

Member

Date:_____ Assessment completed by: _____
Name Title

Last name: _____ First name:_____

ID #: _____ DOB: _____

Physician: _____ Phone:_____Fax: _____

Contact name: _____ Phone:_____Fax: _____

Assessment

1. Medical history and reason for referral:

2. Patient's understanding of current disease status and overall prognosis:

   Medical care options discussed with patient:

3. Has patient completed an Advance Care Planning conversation, including designation of patient advocate as part of the advance directive, with a certified ACP facilitator*? Yes ☐ No ☐ If no, answer questions 4-9. If yes, this form is complete.

4. What are patient's wishes/goals for remainder of life (quality of life vs. length of life; importance of physical comfort; how patient wishes to spend time, etc.)?

5. How does patient describe their current physical/mental symptoms? What is quality of life rating using QOL, HR QOL scale, SF 36 (short-form health questionnaire)?

6. Spiritual or cultural beliefs related to illness and death that would affect enrollment? Yes ☐ No ☐

7. Is advance directive complete? Yes ☐ No ☐
   (i.e. Making Choices Michigan)

8. Patient has designated a durable power of attorney for healthcare? Yes ☐ No ☐

9. Does family/patient advocate support patient's preference for medical care as outlined in advance directive? Yes ☐ No ☐

*Certified ACP facilitators are trained through the Respecting Choices® curriculum. Trained facilitators are available at health systems, Making Choices Michigan, and community organizations.

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