Organisation name Site or unit		FORM Patient goals, values and wishes record	
Document ID	ONC-FRM-004	**Version**	1.0
Status	Blank form, to adapt	**Issue date**	
Review date		**Replaces**	
Owner		**Approved by**	
Signature			

Form · ONC-FRM-004 · Version 0.1 · Draft for local review

Supports: 51.11

At a glance

- Completed in a conversation with the patient, in private, and reviewed as the illness progresses.
- Records what matters most to the patient, their goals, their concerns and their wishes for future care.
- Records any advance directive, the person they have chosen to speak for them, and any treatment limits agreed.
- Copied to the notes and shared with the palliative care and primary care teams with the patient's agreement.
- Stop and review the form if: the patient's condition or treatment changes, or the patient asks for a change.

1. 1. Purpose

To record the patient's goals, values and wishes, including any advance directive, so that treatment is planned around what matters to the patient, and so that the record is reviewed as the illness changes (51.11).

2. 2. How to use this form

- Complete the form with the patient, or with the patient and the person they choose, in a private room, with a professional interpreter if needed.

- Use the patient's own words where possible. Do not complete the form from the notes alone.
- If the patient does not want to discuss this now, record that they have been offered the conversation and the date to offer it again.
- Keep the form in the notes and review it at each change in treatment, and at least every three months.

3. 3. Patient details

Field	Entry
Patient name and identifier	
Date of birth	
Diagnosis and current treatment	
Date of this conversation	
People present, and their relationship	
Interpreter used (name and language)	

4. 4. Understanding and information

Question	Patient's answer (in their words)
What do you understand about your illness now?	
How much information would you like about what may happen?	
Who else would you like to be told about your illness and care?	

Question	Patient's answer (in their words)

5. 5. Goals, values and wishes

Question	Patient's answer (in their words)
What matters most to you in the time ahead?	
What are your biggest worries or fears?	
What gives you strength and comfort?	
What abilities are so important to you that you would accept some treatment burden to keep them?	
What would be unacceptable to you, even if it might help?	
Where would you prefer to be cared for, and where would you prefer to die if that is a question you wish to discuss?	

6. 6. Treatment and resuscitation

Item	Record
Current treatment goal (cure, control, or comfort), as explained to the patient	
Treatment limits discussed, and any agreed decision	
Resuscitation decision, in line with the facility policy, with the reasons	
Clinician who led the discussion, and date	

Item	Record

> Any treatment limit or resuscitation decision must be made according to the facility's policy and confirmed by the responsible doctor. This form records the discussion; it does not replace the policy.

7. 7. Advance directive and representative

Item	Record
Written advance directive held? (yes, no, not discussed)	
Where the directive is held	
Person the patient has chosen to speak for them, with contact details	
Date the representative was confirmed	

8. 8. Review and sharing

Item	Record
Next review date	
Shared with palliative care team (date and name)	
Shared with primary care team (date and name)	
Patient agreed to sharing (yes or no)	

Item	Record

9. 9. Signatures

Role	Name	Signature	Date
Patient (or representative)			
Clinician leading the discussion			
Interpreter (if used)			

10. References

1. Ariadne Labs. Serious Illness Conversation Guide. Current edition.
2. NICE. NG31: End of life care for adults. 2016.
3. Facility advance directive and resuscitation policy (to be inserted by the unit at adoption).

11. Change history

Version	Date	Change
0.1	2026-10-26	First draft for review. Not yet approved by the ASF Expert Committee.

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Related standard

- **Standard 49: Advance Care Planning, Palliative Needs and Dignity**