Feedback form for the physician

Name
Date of birth

Preferences for communication about the end-of-life

□ The patient wants to talk with you about his/her preferences for end-of-life care

□ The patient thinks that you probably don't know his/her preferences for end-of-life care.

General goals of care

□ The best possible quality of life. (tick the box if this is the most important)

□ To live as long as possible. (tick the box if this is the most important)

□ _____

□ _____

Life-sustaining treatments

The patient doesn't have a preference, and do / didn't want to talk about it.

□ The patient wants / doesn't want CPR during cardiac arrest.

□ The patient wants / doesn't want invasive ventilation when spontaneous breathing is not possible.

□ The patient wants / doesn't want non-invasive ventilation.

Other preferences for end-of-life care

□ None

□ Advance directive, i.e. _____

□ Surrogate decision maker, i.e. _____

□ _____

Questions about end-of-life care

□ None

□ Fear of choking

□ _____

□ _____

Signature **Date**