Medical Decision-Making Report

Questions		Answers
DECISION COMMUNICATED		□ Phone □ In Person □ In Writing □ Other Day, Date, Time ___________________________
		Who received decision communication? (Name, Title, Contact Info)
MEDICAL DECISION DESCRIPTION		Consent or refusal for ____
CONTACT INFO		
Client		
Treating Physician/Group		
1st Opinion Name + Specialty		
2nd Opinion Name + Specialty		
3rd Opinion Name + Specialty		
DIAGNOSIS/TREATMENT INFO		
Medical Condition/Diagnosis		
Recommended Treatment Description		
Urgency of Treatment		□ Emergency □ 6 Months □ More than 1 Year
Hospital Stay		□ Inpatient □ Outpatient
Anesthesia		□ Yes, what? □ No
Recovery from Treatment		□ Difficult □ Rehab □ Brief □ Lengthy
Risks + Losses Due to Treatment		
Benefits + Positive Outcomes		
Alternative Treatments		
Conflicting Medicines		
PATIENT OPINIONS		
Patient Has Been Informed		
Patient Willingness/Feedback		
Patient Conflicting Values or Issues		□ Physical □ Social □ Moral/Religious
CONSENT		□ Yes, what? □ No
Treatment or alternative scheduled		□ Yes, what? □ No
NOTES		