

Documenting Advance Care Planning and Goals of Care in CST Cerner: A Step-by-Step Guide and Case Example

The purpose of this document is to provide support for health care professionals and most responsible practitioners (MRPs) in Advance Care Planning (ACP) and Goals of Care (GOC) conversations and documentation. Pages 1-4 of this document contain essential information related to documenting ACP and GOC in CST Cerner. The remainder of the document includes a case example and screenshots.

- ACP, GOC, and Substitute Decision Makers (SDM) should be documented in CST Cerner using the following PowerForms:
 - Advance Care Planning
 - Goals of Care
 - Temporary Substitute Decision Maker and Substitute Decision Maker (TSDM and SDM)
 - Oncology Non-Curative Intent
- Scanned documents can be tagged with ACP Note Types.
- Code status should be documented in CST Cerner when medically indicated. Note that Code Status may be referred to as Medical Orders for Scope of Treatment (MOST), or at BC Cancer specifically, Goals of Care Orders. Note distinction between Goals of Care orders (i.e., code status order) and GOC conversation.
 - Go to page 3 for more information on entering and viewing code status.

Documenting using these tools ensures all ACP and GOC information appears in the ACP and GOC section of CST Cerner.

If the patient had previous encounters with documented ACP and GOC in place, the information will be pulled forward into the applicable fields within the ACP and GOC section of CST Cerner and is viewable across encounters. All previous ACP and GOC information including code status history is also viewable from the [Results Review](#) tab.

Go to page 8 to see screenshots.

Contact acp@phsa.ca with any questions about the information in this document.

How to use the PowerForms:

ACP PowerForm	Goals of Care PowerForm	Substitute Decision Maker (TSDM/SDM) PowerForm	Oncology Non-Curative Intent PowerForm
Discussions/documents prior to this encounter or updates to ACP documents on this encounter: - advance care plans (formal or informal discussions/records of health wishes) - advance directives - representation agreements - palliative care benefits - existing provincial No CPR form	Discussions (during this encounter) regarding: - illness understanding, goals/values, fears, trade-offs, preferences - code status/medical orders for scope of treatment conversations - prognosis shared by team (time-based, functional, level of dependency)	Information about substitute decision makers for a patient, which can be: - under authority of a representation agreement, - court appointed committee of person, - or temporary appointment under section 16 of the Health Care (Consent) and Facility (Admission) Act.	Indicates when a patient is undergoing treatment with non-curative intent, to help inform goals of care conversations, including: - prognosis - the surprise question, “would you be surprised if this patient died within the next year?”

Note Types:

External documents can be scanned into CST Cerner using the ACP note types. Doing so ensures these scanned documents appear in the ACP and Goals of Care section in CST Cerner. The representation agreement and advance directive note types will allow the system to push these documents to CareConnect for shared understanding across care settings.

When sending documents to Health Information Management (HIM) to be scanned, indicate the appropriate note type from the list.

ACP Note Types:

- Advance Directive
- Medical Order for Scope of Treatment
- No CPR – BC Emergency Health Services
- Representation Agreement (section 7)
- Representation Agreement (section 9)
- Advance Care Planning

Code Status/ Medical Orders for Scope of Treatment /Goals of Care Orders

At BC Cancer, the terms “Code Status”, “Medical Orders for Scope of Treatment” (MOST), and “Goals of Care Order” are interchangeable. “Code status” is technically the MOST or Goals of Care Order designation that is entered in CST Cerner. The term “Code Status” is used in this document for simplicity and alignment with language used in CST Cerner.

There are ongoing challenges with entering and viewing up-to-date code status orders in CST Cerner at BC Cancer. As of August 2026, the appropriate procedure for code status and MOST form documentation is currently under review by BC Cancer, PHSA, and Clinical Informatics and will be updated as soon as possible.

Entering Code Status:

When entering a code status order, ensure it is on a **recurring encounter**. Code status is discontinued when an encounter is discharged.

BC Cancer specific information on updating and entering new code status orders on CST Cerner can be found on the [BC Cancer CST Cerner SharePoint site](#).

Viewing Code Status:

As of August 2026, full instructions for entering code status properly in light of ongoing challenges with CST Cerner are under review by BC Cancer Clinical informatics and will be available on their SharePoint page.

You can view code status in the Banner Bar or using [Results Review](#).

BC Cancer specific information on viewing code status orders on CST Cerner can be found on the [BC Cancer CST Cerner SharePoint site](#).

Important information about code status:

- Code status is a medical order signed by the MRP. Ideally, a code status order is accompanied by a regional health authority MOST or provincial No CPR form. A MOST is not a patient consent form.
- Code status is not required for all patients. It is recommended for people living with advanced medical illness.
- Complete code status after ACP and GOC conversations with patients and/or those who matter to them.
- All members of the health care team can contribute to a code status designation by engaging in ACP conversations and documenting conversation outcomes using the applicable PowerForms.
- MRPs select a code status designation based on their clinical judgment of the client’s current health status.
- DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) designations do not mean airway issues are not treated. If a client is choking, a health care professional is expected to attempt to clear the airway. If obstruction escalates to a cardiac arrest, the DNACPR order applies.

Case Example

Background

Alice Tran is a 64-year-old woman with advanced breast cancer and is receiving palliative chemotherapy at BC Cancer - Vancouver. Outside of her oncology care, she also receives treatment for diabetes through a clinic at Vancouver General Hospital.

Both BC Cancer and Vancouver Coastal Health (VCH) sites use the CST Cerner electronic health record. Since Alice accesses care in VCH, this means her medical information, including oncology reports and hospital visits, are recorded in one shared digital environment that clinicians at both organizations can access to support care decisions.

At BC Cancer - Vancouver

During an oncology follow-up appointment, Alice reports worsening fatigue, occasional breathlessness, and new concerns about her health that affect her ability to care for her grandchildren, which she does twice a week.

The oncology nurse looks at the Advance Care Planning (ACP) and Goals of Care section of Alice's chart and can see that she has had previous conversations with her medical oncologist about ACP and her Goals of Care. However, there is no documentation indicating a designated substitute decision maker and she does not see evidence of a conversation about resuscitation (i.e., code status).

The nurse asks Alice about her substitute decision maker (SDM) and learns that she has a section 7 representation agreement naming her daughter as her representative. In their handover, the nurse mentions to the medical oncologist that Alice has not had a conversation about her wishes related to code status.

The oncologist continues the conversation with Alice about goals of care and code status and they agree on a designated code status level that aligns with her wishes and condition. The oncologist completes and enters the code status order on CST

Cerner. She also completes the Provincial No CPR form. Alice's code status is viewable in the banner bar at the top of the screen and is also viewable in **Results Review**. Alice gets a copy of her No CPR form to take home and is told to bring it with her if she goes to the hospital.

The nurse and oncologist use the **Goals of Care PowerForm** and the **Advance Care Planning PowerForm** within CST Cerner to document the detailed conversation, including the conversation about code status. The **Temporary Substitute Decision Maker/Substitute Decision Maker PowerForm** can also be used to document TSDM/SDM information. The oncologist uses the **Oncology Non-Curative Intent PowerForm** to indicate her prognosis and treatment status. They can also scan in any documents using certain note types in CST Cerner. Anything documented using the PowerForms or ACP and Goals of Care note types will show up in the ACP and Goals of Care section of CST Cerner.

The ACP PowerForm includes:

- Documentation about the section seven representation agreement naming her chosen SDM

The Goals of Care PowerForm includes:

- Alice's understanding of her illness and prognosis
- Her values (e.g., wanting to continue caring for her grandchildren)
- Details about the conversation they had about code status
- Documentation about conversations that have included Alice's family members and their understanding of her wishes

The TDSM/SDM PowerForm includes:

- Alice's daughter's name and contact information

Oncology Non-Curative Intent PowerForm includes:

- Alice's prognosis
- Additional information about Alice's palliative therapy that may help inform care providers in other settings about her goals of care

Scanned documents:

- Representation agreement (pushes to CareConnect)
- Code status documentation (MOST form/BC Cancer Goals of Care Order/Provincial No CPR form) (does not push to CareConnect at this time)

The oncologist has also updated the code status order section of the CST Cerner chart as appropriate. Because the PowerForm fields and note types feed into Alice's chart in CST Cerner, the information is immediately visible to all authorized care providers across BC Cancer, VCH, and other relevant CST Cerner sites.

Unscheduled Emergency Department Visit at VGH

A week later, Alice goes to the Vancouver General Hospital Emergency Department (ED) with shortness of breath and chest pain. It is determined that Alice has a pulmonary embolism.

When triage and ED physicians open Alice's record in the CST Cerner system, they open the ACP and Goals of Care section and see:

- Her recent oncology notes and chemotherapy regimen
- The ACP and Goals of Care, and Non-Curative Intent PowerForms completed at BC Cancer
- Her SDM (including a representation agreement) and code status documentation

As this documentation was properly completed using the PowerForms and Note Types, the ED team doesn't have to hunt through narrative text, call BC Cancer to clarify Alice's wishes, or ask Alice to repeat all of this information again. The care team asks Alice if they can contact her daughter to come to the hospital, and is able to adjust clinical decisions based on Alice's expressed goals, such as avoiding overly aggressive interventions that conflict with her priorities.

Family Physician Follow-up

Alice has a family physician who she sees regularly to help manage her symptoms and other health concerns. Her family physician knows her well, but they have not had a conversation about ACP up to this point. Her physician is aware of Alice's

recent hospitalization and can see information about Alice's representation agreement on CareConnect, but no other details related to ACP. She plans to initiate a follow-up ACP conversation with Alice, asking her to bring a copy of her ACP information to her next appointment.

Conclusion

Proper documentation is foundational to ensuring that interdisciplinary teams working in different clinical contexts can see, trust, and act on the same patient information in pursuit of better outcomes.

Screenshots

Results Review: View ACP, GOC and code status history

Menu

- Rehab Summary
- Patient Summary
- Mental Health Summary
- Provider View
- Women's Health Overview
- Orders + Add
- Single Patient Task List
- MAR
- MAR Summary
- Interactive View and I
- Results Review**
- Documentati... + A
- Documentation Filter
- Histories
- Allergies
- Diagnoses and Probl
- Appointments
- Calculators
- CareConnect
- Clinical Media
- Clinical Research

Results Review

Vitals - Extended

Recent Results **Advance Care Planning** Lab - Recent Lab - Extended Lab - Provincial Pathology Microbiology Cultures Microbiology Other Transfusion Diagnostics Vitals - Recent

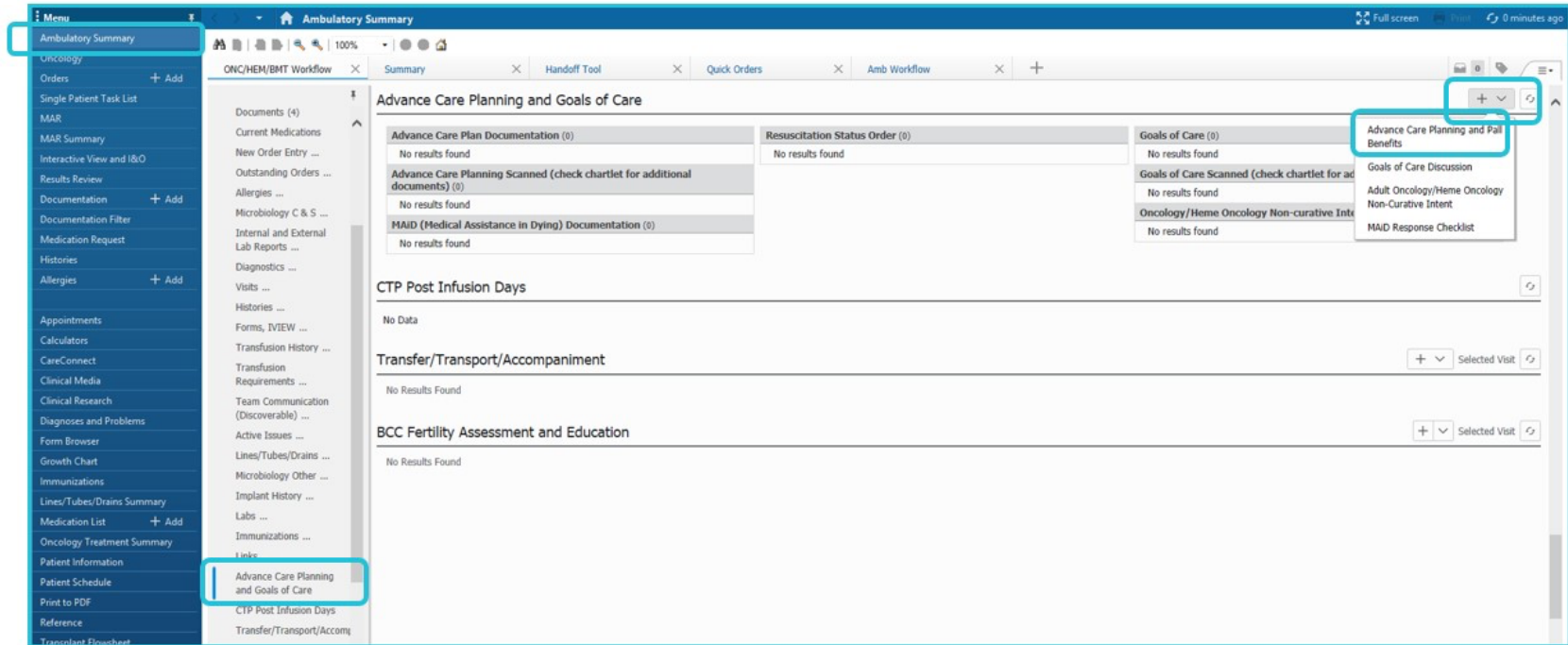
Flowsheet: Advance Care Planning View Procedure Select Level: Advance Care Planning View Table Group List

Saturday 06-May-2023 17:29 PDT - Thursday 06-May-2027 17:29 PDT (Clinical Range)

Showing results from (17-Sep-2025 - 05-May-2026) Show more results

Advance Care Planning View							
Code Status - Adult							
03-May-2026 12:20 PDT	4-No CPR, Critical Care, ...	Attempt CPR, Full Code	Attempt CPR, Full Code	Attempt CPR, Full Code			
16-Mar-2026 04:52 PDT	4-No CPR, Critical Care, ...	Attempt CPR, Full Code	Attempt CPR, Full Code	Attempt CPR, Full Code			
19-Jan-2026 21:21 PST	4-No CPR, Critical Care, ...	Attempt CPR, Full Code	Attempt CPR, Full Code	Attempt CPR, Full Code			
Advance Care Plan Information							
05-May-2026 21:50 PDT	Yes	Section 7 Standard Repr...	Unable to obtain copy	Copy left at home, wife ...			
16-Mar-2026 10:35 PDT	Unable to answer at this ...	Section 7 Standard Repr...	Unable to obtain copy	Copy left at home, wife ...			
12-Mar-2026 11:39 PDT	Yes	Section 7 Standard Repr...	Unable to obtain copy	Copy left at home, wife ...	No		
20-Jan-2026 01:54 PST	No	Section 7 Standard Repr...	Unable to obtain copy	Copy left at home, wife ...		No	
02-Oct-2025 11:11 PDT	Yes	Section 7 Standard Repr...	Unable to obtain copy	Copy left at home, wife ...			
17-Sep-2025 09:54 PDT	Yes						
Advance Care Planning Documentation							
Medical Orders for Scop...							

ACP Documentation: ACP Details



The screenshot displays the 'Ambulatory Summary' interface. The left sidebar contains a 'Menu' with various navigation options. The main content area is titled 'Advance Care Planning and Goals of Care' and includes sections for 'Advance Care Plan Documentation', 'Resuscitation Status Order', 'Goals of Care', 'CTP Post Infusion Days', 'Transfer/Transport/Accompaniment', and 'BCC Fertility Assessment and Education'. A red box highlights the 'Advance Care Planning and Goals of Care' section in the sidebar. Another red box highlights the 'Advance Care Planning and Goals of Care' section in the main content area, which is currently expanded to show a list of documents: 'Advance Care Plan Documentation (0)', 'Advance Care Planning Scanned (check chartlet for additional documents) (0)', 'MAID (Medical Assistance in Dying) Documentation (0)', 'Resuscitation Status Order (0)', 'Goals of Care (0)', 'Goals of Care Scanned (check chartlet for additional documents) (0)', 'Oncology/Heme Oncology Non-curative Intent', and 'MAID Response Checklist'.

Menu

- Ambulatory Summary
- Oncology
- Orders + Add
- Single Patient Task List
- MAR
- MAR Summary
- Interactive View and I/O
- Results Review
- Documentation + Add
- Documentation Filter
- Medication Request
- Histories
- Allergies + Add
- Appointments
- Calculators
- CareConnect
- Clinical Media
- Clinical Research
- Diagnoses and Problems
- Form Browser
- Growth Chart
- Immunizations
- Lines/Tubes/Drains Summary
- Medication List + Add
- Oncology Treatment Summary
- Patient Information
- Patient Schedule
- Print to PDF
- Reference
- Transplant Dashboard

Documents (4)

- Current Medications
- New Order Entry ...
- Outstanding Orders ...
- Allergies ...
- Microbiology C & S ...
- Internal and External Lab Reports ...
- Diagnostics ...
- Visits ...
- Histories ...
- Forms, IVIEW ...
- Transfusion History ...
- Transfusion Requirements ...
- Team Communication (Discoverable) ...
- Active Issues ...
- Lines/Tubes/Drains ...
- Microbiology Other ...
- Implant History ...
- Labs ...
- Immunizations ...
- Links
- Advance Care Planning and Goals of Care**
- CTP Post Infusion Days
- Transfer/Transport/Accompaniment

Advance Care Planning and Goals of Care

Advance Care Plan Documentation (0)	Resuscitation Status Order (0)	Goals of Care (0)
No results found	No results found	No results found
Advance Care Planning Scanned (check chartlet for additional documents) (0)		Goals of Care Scanned (check chartlet for additional documents) (0)
No results found		No results found
MAID (Medical Assistance in Dying) Documentation (0)		Oncology/Heme Oncology Non-curative Intent
No results found		No results found

CTP Post Infusion Days

No Data

Transfer/Transport/Accompaniment

No Results Found

BCC Fertility Assessment and Education

No Results Found

ACP Documentation: ACP Powerform



Advance Care Planning and Pall Benefits - VPTEST, CSTLGHFIFTEEN

*Performed on: 11-Sep-2024 1513 PDT By: Kilgour, Heather, RN

Advance Care Planning

BC Palliative Services

Advance Care Plan ☐ Yes ☒ No ☐ Unable to answer at this time	Patient Wishes to Receive Further Information on Advance Care Planning ☒ Yes ☐ No Please provide information as able or if necessary, consult to another profession or department such as social work or counselling.
Type of Advance Care Plan ☐ Advance Care Plan ☐ Section 7 Standard Representation Agreement ☐ Section 9 Enhanced Representation Agreement ☐ Advance Directive ☐ No Cardiopulmonary Resuscitation - Medical Order ☐ Refusal of Blood Product ☐ Other:	Advance Care Plan Details Reviewed ACP Educational Resource with patient in detail.
Location of Advance Care Plan ☐ Copy to be obtained from previous records ☐ Copy placed on paper chart ☐ Family to bring in copy from home ☐ Available as scanned document in EHR ☐ Unable to obtain copy ☐ Other:	Reason Copy Cannot Be Obtained
Palliative Care Benefits ☐ Yes ☒ No Please engage in discussion regarding goals of care or a serious illness conversation.	

*The ACP Details box allows very few characters – recommend documenting details in GOC Powerform

ACP Documentation: Exploratory Conversations



The screenshot displays the "Ambulatory Summary" application interface. On the left is a blue sidebar menu with various options. The main content area is titled "Advance Care Planning and Goals of Care" and contains several sections: "Advance Care Plan Documentation (0)", "Resuscitation Status Order (0)", "Goals of Care (0)", "Advance Care Planning Scanned (check chartlet for additional documents) (0)", "MAID (Medical Assistance in Dying) Documentation (0)", "CTP Post Infusion Days", "Transfer/Transport/Accompaniment", and "BCC Fertility Assessment and Education". A dropdown menu is open on the right side of the "Goals of Care (0)" section, listing options: "Advance Care Planning and Palliative Care", "Goals of Care Discussion", "Adult Oncology/Heme Oncology Non-Curative Intent", and "MAID Response Checklist". The "Goals of Care Discussion" option is highlighted. The sidebar menu has "Advance Care Planning and Goals of Care" selected. The top of the interface shows tabs for "Summary", "Handoff Tool", "Quick Orders", and "Amb Workflow".

Exploratory Conversations: Goals of Care Powerform

Goals of Care Discussion - VPPTST, CSTLGHFIFTEEN

Performed on: 11-Sep-2024 1515 PDT By: Kilgour, Heather, RN

Goals of Care Discussion

Goals of Care Discussion Date and Time:

The Patient's Ability to Participate in Goals of Care:

☒ Is able to express goals of care at this time
☐ Is NOT currently able to express goals of care [seek SDM]

Details of Inability to Participate in Discussion:

Decision Maker Involved in Development of Goals of Care:

☒ None ☐ Other:
☐ Parent/Guardian
☐ Patient
☐ Representative
☐ SDM

Name of Decision Maker Involved:

Goals of Care Discussion Details:

Include:

- * Patient and family awareness of current situation or condition and prognosis.
- * Patient values, wishes or hopes.
- * Patient's fears or things they wish to avoid.
- * If patient is unable to participate in discussion, confirm with Substitute Decision Maker that they are representing the patient's wishes.
- * Patient priorities or trades-offs for chance of extended life

Applicable Palliative Care Identifiers (Check all that apply):

☐ Advance Care Plan/Living Will/Goals of Care Documentation
☐ Frailty Scale
☐ Diagnostic Criteria (SPICIT)
☐ Surprise Question

Engaged in an exploratory conversation with patient using the ACP Conversation Guide: Understanding What Matters Most. Patient states his family is what matters most to him, identifying his wife, Sarah, and his two daughters, Iris and Sylvie. He worries about being a burden to them as he navigates cancer care. Patient reassured that his healthcare team is here to support both him and his family, and that we will check in with him regularly regarding feeling like a burden. Patient states he wants to do everything he can to be healthy for his family, including receiving cancer treatment, eating a balanced diet, and remaining active.

Patient identified his wife Sarah as his SDM. Encouraged patient to discuss his wishes with Sarah and provided patient the Conversation Starters handout.

Patient advises we will have ongoing conversations related to what matters most to him, his wishes and fears.

Version 2 Feb. 27, 2019

In Progress

ACP Documentation: SDM

A screenshot of a web-based patient information system. The interface includes a blue sidebar menu on the left with various navigation options. The main content area is titled "Ambulatory Summary" and contains several tabs for patient information. A red box highlights the "Patient Information" tab in the sidebar. Another red box highlights the "Patient Preferred Info" sub-tab within the "Patient Information" section. A third red box highlights the "TSDM and SDM" option in a dropdown menu. The main content area displays patient details such as contact information, emergency contacts, and insurance status. The "Substitute Decision Maker and Temporary Substitute Decision Maker" section indicates that the TSDM and SDM Powerform has not been completed. The "Oncology PowerPlans and Regimens" section shows a table with no results found for the current period.

Menu

Ambulatory Summary

Uncology

Orders + Add

Single Patient Task List

MAR

MAR Summary

Interactive View and I&O

Results Review

Documentation + Add

Documentation Filter

Medication Request

Histories

Allergies + Add

Appointments

Calculators

CareConnect

Clinical Media

Clinical Research

Diagnoses and Problems

Form Browser

Growth Chart

Immunizations

Lines/Tubes/Drains Summary

Medication List + Add

Oncology Treatment Summary

Patient Information

Patient Schedule

Print to PDF

Reference

Transplant Flowchart

Chief Complaint / History of Visit

Patient Information

and Regimens

Home Medications (1)

Vital Signs and Measurements

Documents (6)

Current Medications

New Order Entry

Outstanding Orders ...

Allergies ...

Microbiology C & S ...

Internal and External Lab Reports ...

Diagnostics ...

Visits ...

Histories ...

Forms, IVIEW ...

Transfusion History ...

Transfusion Requirements ...

Team Communication (Discoverable) ...

Active Issues ...

Lines/Tubes/Drains ...

Microbiology Other ...

Patient Information

Information

Gender and Pronouns

Patient Preferred Information

Community Contacts

Additional Contacts

Provider Relationships

This is Me

Patient Contact Information

Preferred Name

Preferred Phone

Home

Business

Mobile

Alternate Phone

Email

Home Address

Emergency Contact Name

Relationship

Phone Number

Ethnicity

Primary Language

Interpreter Required

Indigenous Identity

Indigenous Identity

Non Indigenous

Substitute Decision Maker and Temporary Substitute Decision Maker

TSDM and SDM Powerform has not been completed.

Guardianship

Child Guardianship

Community Support Contacts

Patient Preferred Info

TSDM and SDM

This is Me

Oncology PowerPlans and Regimens

Add Outside Administration: Search Plan

Current(0)

Name	Response	Status	Start
No results found			
Historical(0)- 15/03/2024 to Current			

ACP Documentation: SDM Powerform

TSDM and SDM - VPPTST, CSTLGHFIFTEEN

*Performed on: 11-Sep-2024 1534 PDT

Temporary Substitute Decision Maker

Name (first and last name)
Sarah Smith

Relationship

☐ No relationship given	☐ In-law
☐ Caregiver	☐ Lawyer
☐ Child	☐ Neighbor
☐ Common law	☐ Parent
☐ Community care worker	☒ Partner/spouse
☐ Foster child	☐ Public guardian and trustee
☐ Foster parent	☐ Relative
☐ Friend	☐ Sibling
☐ Grandchild	☐ Unknown
☐ Grandparent	☐ Other:

Domain

☒ TSDM
☐ Committee of person/personal guardian
☐ Representative 7
☐ Representative 9

[Scroll to bottom of form to view TSDH Reference Information.](#)

Preferred Phone:
☐ Home
☒ Mobile/Pager
☐ Work phone + extension
☐ Alternate phone number

Home Phone Number

Work Phone Number

Email

Mobile/Pager Number
 778-808-7788

Alternate Phone Number

Legal Documents Provided
☐ Yes
☒ No

Legal Documents Sent to Health Records
☐ Yes
☒ No

Appointed By:
 Patient

Appointed for Single vs Course of Treatments
☐ Single
☒ Course

Treatment Type
 Chemotherapy and Supportive Care

TSDM End Date

TSDM Additional Comments
 TSDM Sarah is aware of her role and of patient's wishes

ACP Documentation: SDM

Menu Ambulatory Summary

ONC/HEM/BMT Workflow Summary Handoff Tool Quick Orders Amb Workflow

Chief Complaint / Reason for Visit

Patient Information

Information Gender and Pronouns Patient Preferred Information Community Contacts Addressed Contacts Provider Relationships This is Me

Patient Contact Information

Preferred Name	Preferred Phone	Home
--	(000)000-0000	(000)000-0000
Business	Mobile	Alternate Phone
--	--	--
Email	Home Address	
--	0 Noname Street Vancouver, British Columbia V0V0V0	
Emergency Contact Name	Relationship	Phone Number
UNKNOWN, UNKNOWN	Unknown	--
Ethnicity	Primary Language	Interpreter Required
--	--	--
Indigenous Identity		
Indigenous Identity		
Non Indigenous		

Substitute Decision Maker and Temporary Substitute Decision Maker

TSDM Name	Relationship	Legal Authority	Appointed by
Sarah Smith	Partner/spouse	TSDM	Patient
Preferred Phone	Home	Mobile	Appointed for Treatment Course
--	778-808-7788	--	
Business	Alternate Phone	Treatment Type	
--	--	Chemotherapy and supportive care.	
Email			
--			
TSDM Comments			
SDM Sarah is aware of her role and of patient's wishes.			

Guardianship

Oncology Non-Curative Intent

09-Mar-2021 0925 PST By: TestCST, OncologistHematologist-Physician1 ON

Adult Oncology/Heme Oncology Non-Curative Intent

Non-Curative Intent ☒ Yes ☐ No

Prognosis ☐ Years ☐ Months

Would You Be Surprised If This Patient Died In The Next Year? ☐ Yes ☐ No

Other Relevant Information

Segoe UI 9

Please Review:

Code Status

Enter or update code status in the **Patient Care** section on the Quick Order page:

Patient Care

- ▶ Patient Disposition
 - ▾ Code Status
 - Code Status Attempt CPR, Full Code
 - Code Status 1-No CPR, Supportive Care, No Intubation
 - Code Status 2-No CPR, Therapeutic Care, No Intubation
 - Code Status 3-No CPR, Acute Transfer, No Intubation
 - Code Status 4-No CPR, Critical Care, No Intubation
 - Code Status 5-No CPR, Critical Care, May Intubate
 - ▶ General Communication
 - ▶ Activity
 - ▶ Diets
 - ▶ Lines/Tubes/Drains
 - ▶ Wound Care

Once a code status order has been placed, it will show on the **Banner Bar**:

HOSPITAL, APPLE				← List → Recent ▾ Name	
HOSPITAL, APPLE	DOB:15-Mar-1980	MRN:740024492	Code Status:2-No CPR, Therapeutic Care, No Intuba...	Process:Falls Risk	Location:VGH T6B; T6BL; 02
	Age:43 years	Enc:7400000075005		Disease:	Enc Type:Inpatient; Active
Allergies: penicillin, Dust	Gender:Female	PHN: 9873641236	Dosing Wt: 58 kg (23-JUN-2023)	Isolation:	Attending:Test, Alex

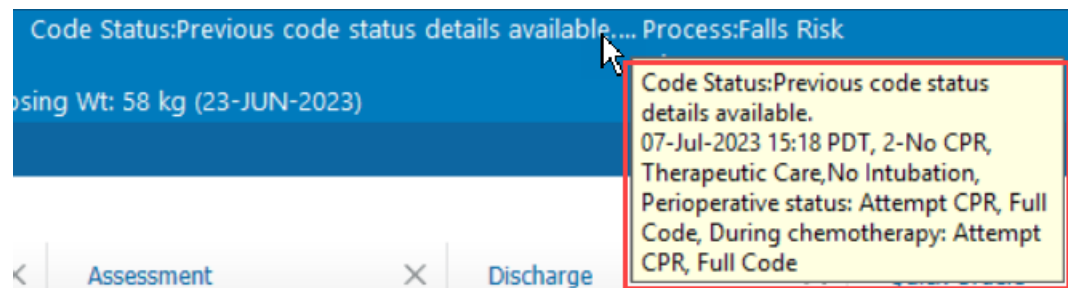
Hover your mouse over the **Code Status** message to display additional details as shown in the screenshot below.

Code Status:2-No CPR, Therapeutic Care, No Intuba...Process:Falls Risk

Dosing Wt: 58 kg (23-JUN-2023)

Code Status:2-No CPR, Therapeutic Care, No Intubation
07-Jul-2023 15:18 PDT, Perioperative status: Attempt CPR, Full Code, During chemotherapy: Attempt CPR, Full Code

The patient may have more than one encounter. If an active **Code Status** order is placed in one encounter, the Banner Bar of other active encounters will display the message - **Previous code status details available**. Hovering over the **Code Status** message will display the most up-to-date Code Status order details as shown in the screenshot below. Note that if a code status order is placed in an encounter that is subsequently discharged, that code status order will not display.



View previous code status details in **Results Review**. Note that if a code status order is placed in an encounter that is subsequently discharged, that code status order will not display.

Results Review

Recent Results **Advance Care Planning** Lab - Recent Lab - Extended Lab - Provincial Pathology Microbiology Cultures

Flowsheet: Advance Care Planning View ... Level: Advance Care Planning View ☒ Table ☐ Group

Thursday, 27-April-2017

Showing results from (17-Dec-2019 - 27-Apr-2020) Show more results		
Advance Care Planning View	27-Apr-2020 13:14 PDT	27-Apr-2020 13:13 PDT
Code Status		
Code Status Type	5-No CPR, Critical Care...	
Perioperative Status	Attempt CPR, Full Code	
During Chemotherapy Status	Attempt CPR, Full Code	
Advance Care Plan Information		
Advance Care Plan		Yes
Advance Care Plan Details		NO CPR
Advance Care Plan Type		Advance Care Plan
Goals of Care		