Appendix. The Medical Decision Worksheet (continued)

- *Understanding my physician's recommended option*

(Physician: describe the approach)

- *The benefits of the recommended option*

(Physician: list expected benefits and note how likely they are to occur)

- *The risks of the recommended option*

Common risks include:
(Physician: list, and note how common)

The most serious risks include:
(Physician: list, and note how common)

- *Learning and knowing my own mind*

A list of items to consider:
☐ Has my physician given me all the information that I want?
☐ Has my physician encouraged me to raise issues and helped me to develop my thinking about this decision?
☐ Have I had access to information (brochures, videos, etc) and time to think about it before I decide?
☐ Have I had reasonable opportunities to talk with support groups or other people who have been in similar circumstances?
☐ Has my nurse or other health care provider been available to talk things through with me?

- *My values, culture, and family participation*

A list of items to consider:
☐ Have I expressed to my physician my relevant values and relevant aspects of my culture and community?
☐ Do I think that any language or communication barrier prevented a good decision?
☐ Do I feel that my decision fits with my values and culture?
☐ Have my family members/friend(s) been involved in this decision as much as I wanted?

- *Understanding my decision*

My decision is:
I understand that if I go ahead with this decision, major consequences will likely be:

This is a reasonable decision for me because:

- *My physician will honor our decision for my medical care*

A list of items to consider:
☐ Is there significant conflict between my wishes and my physician's professional judgment? Do we agree on the decision?
Or
☐ Have I declined the recommended approach and, with a settled mind, decided to take a different one?

If you are not comfortable with any of your responses to these items consider talking to your health care providers about it.
Patient Signature:
Printed Name:
Address:
Contact Number:

I certify that the patient is over 18 years of age and competent to agree to (name procedure or test:)
Physician Signature:
Printed Name:
Address:
Contact Number:

Optional:
Witness Signature:
Printed Name:
Address:
Contact Number:
Date: