

Serious Illness Conversation Assessment Tool

Use this form to take notes while observing another clinician during a SI Conversation. Provide feedback.

Component	Description	Comments:
Identify for SI conversation	<ul style="list-style-type: none"> ▪ Accurately identifies criteria that qualified patient for SI conversation 	
Introduces Conversation (Step 1)	<ul style="list-style-type: none"> ▪ Describes the purpose of the conversation- align care with goals if patient were to get sicker 	
Discusses Understanding of Health (Step 2)	<ul style="list-style-type: none"> ▪ Elicits patient understanding of current health condition ▪ Uses probes as needed 	
Elicits Values and Goals of Care (Step 3)	<ul style="list-style-type: none"> ▪ What would be most important if patient gets sicker? ▪ What do they hope for their medical care? ▪ Concerns or worries about medical condition? ▪ Tradeoffs – what are they willing to go through for the possibility of more time? 	
Makes a Plan (Step 4)	<ul style="list-style-type: none"> ▪ Elicits how much family and doctor know about priorities and wishes ▪ Affirms or troubleshoots barriers ▪ Documents in place and in EMR? 	
Summarizes (Step 5)	<ul style="list-style-type: none"> ▪ Reviews what patient verbalized as most important ▪ Reviews who they need to talk to about what is important to them ▪ Reviews forms needed to complete 	
Close and Follow-up Plan (Step 6)	<ul style="list-style-type: none"> ▪ How did the conversation make them feel? ▪ What were some thoughts about what they talked about? ▪ Other next steps? 	

Debrief the conversation as follows, with self-reflections first and observer feedback second:

One thing that went well that I/you should continue doing in the future is ...

One thing that I/you may want to do differently in the future is ...