

**EXAMPLE FINAL DECISION LETTER – PLEASE PRODUCE A VERSION FOR YOUR OWN WORKPLACE**

**Tel:** 020 8780 4500

**Fax**: 020 8780 4511

Date:

**Summary of decision regarding Future Feeding Planning**

|  |  |  |
| --- | --- | --- |
| **Name:** | **Date of birth:** | |
|  |  | |
| **Diagnosis:** | **NHS No:** | |
|  |  | |
| **Relevant ADRT in place:** | **LPA for Health in place:** | |
| YES/NO | YES/NO If yes state who: | |
| **Patient’s family/NOK/other relevant parties aware of decision?** | YES/NO  If no, why: | |
| **Decision:** | | **Date of decision:** |
| * **To not have a feeding tube and to eat and drink at risk.**   ***OR***   * **To have a feeding tube and be made nil by mouth when swallow becomes unsafe.**   ***OR***   * **To have both a feeding tube and continue with some oral intake for quality of life under guidance of a Speech and Language Therapist. This may be safe or unsafe.**   ***Note: this decision should be reviewed annually or more frequently if clinically indicated (e.g. decreased swallow safety, decreased ability to meet nutrition/hydration needs orally).*** | |  |
| **Summary (e.g. how and why the above decision was formulated):** | | |
|  | | |

Many thanks for considering this information,

**Dr responsible for care:** ………………………… (Sign) …………………………….(Name)

**Dietitian:** ………………………………(Sign) …………….……………….(Name)

**Speech Therapist:** ……………………………....(Sign) ……………………………. (Name)

**Psychologist:** ……………………………….(Sign) ……………………………..(Name)

**Power of Attorney for Health and Welfare Representative:**

……………………………………………(Sign) ……………………………………………(Name