CURRENT SITUATION SNAPSHOT

Stage 1 — Observe the Whole Situation — Companion to the Family Health Coherence Method

Purpose: A structured first-picture document that helps a family capture what is known, what is believed, and what remains unknown before recommendations are made.

This resource is an educational and family-coordination tool. It is not a diagnosis, medical directive, emergency assessment, legal instrument, or substitute for a physician, attorney, licensed care provider, or lawful decision-maker.

Privacy: complete and share this document only through methods appropriate for the sensitivity of the information. Do not place protected or highly sensitive health information in marketing analytics, unsecured email, or unapproved storage systems.

A. Document Control

Family or household name: **Person at the center:**

Preferred name: **Date started:**

Completed by: **Relationship or role:**

Version number: **Date last updated:**

B. Why This Snapshot Is Being Completed Now

What prompted this review?

What changed recently? (consider the last 7, 30, and 90 days)

What does the family believe is happening?

What does the person at the center believe is happening?

What decision or action feels most pressing?

C. Current Health Picture

Known diagnoses or health conditions (as communicated by treating professionals):

Current symptoms or concerns (function, comfort, behavior, cognition, communication, routines):

Recent hospital, emergency, rehabilitation, or urgent-care use:

Mobility and fall concerns: **Nutrition and hydration concerns:**

Breathing or respiratory concerns: **Skin, wound, or pressure concerns:**

Pain or comfort concerns: **Cognition, memory, behavior, communication:**

Sleep, emotional well-being, or adjustment: **Allergies or known adverse reactions:**

What appears stable right now?

D. Medications and Treatment Plan

Where is the current medication list? **Who last confirmed/reconciled the list?**

Who orders the medications? Who obtains refills?

Who organizes or administers medications?

Recent medication or treatment changes:

Missed doses, duplicate lists, side effects, or unanswered questions:

Current therapies, equipment, or treatment routines:

E. Providers and Care Settings

Primary physician or lead clinician: Specialists:

Pharmacy: Home-care, nursing, rehab, hospice, or other providers:

Current care setting or recent transitions:

Next known appointments: Unanswered provider questions:

F. Family, Household, and Care Supports

Primary family contact: Primary caregiver:

Other involved family members:

Household or estate manager: Family office or trusted advisor:

Paid caregivers or nurses: Agency or staffing arrangements:

Current schedule or coverage pattern:

Transportation, meals, equipment, supplies, or home-support needs:

What support is reliable? What support is fragile or one-person-dependent?

G. Roles, Authority, and Access — Initial View

Who is currently making day-to-day health decisions?

Who is believed to hold formal healthcare decision authority?

Has that authority been confirmed through the appropriate document or professional?

Where are healthcare proxy, POA, advance directive, insurance, and key records located?

Who can access those records? Who receives updates from clinicians/caregivers?

What permissions or authorizations may still be needed?

H. Records, Schedules, and Communication

Where are health records kept? Is there one current provider roster?

Is there one current medication list? Is there a shared calendar or schedule?

How do family members communicate updates?

How do professional caregivers document or relay information?

Who ensures the right person receives important information?

What information is repeatedly lost, delayed, or misunderstood?

I. Values, Dignity, and Quality-of-Life Priorities

What matters most to the person at the center?

Important routines, relationships, spiritual practices, cultural values, household preferences:

What brings comfort, meaning, independence, or dignity?

What changes would feel especially disruptive or unacceptable?

What tradeoffs is the family currently trying to understand?

J. Known, Believed, and Unknown

What is documented and known?

What is believed but not yet confirmed?

What is unknown?

Who is the right person or professional to confirm each unknown?

K. Readiness for the First Strategy Conversation

Top three concerns:

Decisions likely needed in the next 7 days:

Decisions likely needed in the next 30 days:

Decisions likely needed in the next 90 days:

Who should participate in the conversation?

What documents should be gathered beforehand?

What would make the conversation useful to the family?

Method Handoff

Stage 1 output: a shared picture of the current reality. Move every concern, uncertainty, and likely failure point into the Family Risk Review. Do not assign priority merely because an item was mentioned first.

Keep terminology synchronized with the Family Health Governance Charter for the first point of accountability, decision authority, document location, communication flow, caregiver backup, and review date. The Snapshot gathers the current facts; it does not replace the Charter's governing decisions.