

Name: _____

Address: _____

Phone: _____

DOB: _____ Sex: _____

URN: _____ (Hospital use only)

ADVANCE CARE PLAN STATEMENT OF CHOICES - COMPETENT PERSON

Name of Attorney(s) under Enduring Power of Attorney

1. Name: _____

2. Name: _____

Telephone number(s) of Attorney:

Telephone number(s) of Attorney:

_____ (Home)

_____ (Home)

_____ (Mobile)

_____ (Mobile)

_____ (Work)

_____ (Work)

Relationship: _____

Relationship: _____

3. Name: _____

4. Name: _____

Telephone number(s) of Attorney:

Telephone number(s) of Attorney:

_____ (Home)

_____ (Home)

_____ (Mobile)

_____ (Mobile)

_____ (Work)

_____ (Work)

Relationship: _____

Relationship: _____

Date of the Enduring Power of Attorney (EPA): _____

The following documents have been completed and are attached:

Enduring Power of Attorney: Yes No

Health Direction under the Medical Treatment (Health Directions) Act 2006: Yes No

Registered on the Australian Organ Donor Register: Yes No

For more information about organ and tissue donation contact Donate Life on 6174 5625

I give permission for this information to be shared with my health care team.

Signed: _____ Date: _____

Copies of your Advance Care Plan have been given to: e.g. Canberra and Calvary Public Hospital; GP; Attorney(s) or Guardian; Residential Aged Care Facility; private hospital/health facility *(complete as many lines as applicable)*

1. _____

4. _____

2. _____

5. _____

3. _____

6. _____



DO NOT WRITE IN THIS BINDING MARGIN

This Advance Care Plan will be used to guide future medical decisions ONLY when you lose the ability to make or communicate your medical treatment decisions yourself. The law requires that this statement of your wishes must be taken into account when determining your treatment.

I _____,
(Your name)
of _____,
(Your address)

am of sound mind, and I have read and understand the importance of this document. I have also had this document explained to me and had all my questions answered to my satisfaction. I request that my stated choices recorded below, are respected by my family, appointed attorney(s) and by my doctors. In addition I request that they respect my values and wishes as we have previously discussed.

I understand that it is most important to discuss my wishes with my Enduring Power of Attorney(s), family and doctors so that they are aware of them. I also understand that the doctors will only provide treatment that is medically appropriate.

Living well, or an acceptable recovery/reasonable outcome after illness or injury can mean:

(Example: To be able to communicate meaningfully with family/friends; not be completely bed bound; to not be dependent on others for personal hygiene; to be able to eat and drink naturally; to have some mobility)

*To me 'living well' or an acceptable recovery/reasonable outcome means (please write what is important to you):

My Choices About Life Prolonging Treatments *Initial the box that you want and put a line through the boxes that you do not want.*

e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube (PEG tube or nasogastric tube), operation, intravenous antibiotics, blood transfusion.

I **do** want life prolonging treatments if it is medically appropriate.

Or

In circumstances like those set out below I **do not** want life prolonging treatments at all. If life-prolonging treatment is commenced contrary to my wishes I request that it be discontinued. Circumstances in which I would not want life-prolonging treatments include:

To me life prolonging treatments mean:

Or

I only want life prolonging treatments **if** the doctors expect an acceptable recovery/reasonable outcome as described above.*

Or

I wish to leave the decisions on life prolonging treatments to my Enduring Power of Attorney (if appointed) in consultation with my doctors.

My choices about treatment if my heart stops or there are no signs of life (not moving, unresponsive, not breathing, unconscious).

CPR (Cardiopulmonary Resuscitation) can be attempted to restart a heart.

CPR (Cardiopulmonary Resuscitation) *Initial the box that you want, put a line through the boxes that you do not want.*

I **do** want CPR if it is medically appropriate

Or

I **do not** want CPR at all

Or

I **only want** CPR **if** the doctors expect an acceptable recovery/reasonable outcome as described above.*

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If your choices on the previous page relate to a current medical condition you can complete a Health Direction under the Medical Treatment Act 2006. You can talk to your Advance Care Planning Facilitator or doctor about this

(Complete if applicable)

My current medical condition (include any chronic condition or life limiting illness) _____

I wish to make the following further requests regarding my treatment for the conditions described above: _____

Other points that are important to me

I ask that my Enduring Power of Attorney(s) include the following people in my health care decisions if there is time:

If I am nearing my death, I want the following (list things that would be important to you, e.g. care of a pet, religious or spiritual rituals, cultural customs):

If I am nearing my death and cannot speak, please give my family and friends the following message:

If there is not enough room to write all your requests and wishes, please attach further pages as necessary. All additional pages need to be signed, dated and witnessed.

I _____ hereby declare that the information completed above is a true record of my wishes on this date.

Signature _____ Date _____
(your signature or Mark)

Witness signature _____ Date _____

Witness name _____ Relationship _____

DO NOT WRITE IN THIS BINDING MARGIN

Frequently Asked Questions

What is Advance Care Planning?

Advance care planning (ACP) is a series of steps you can take to help you plan for your future health care. ACP is based on the principles of autonomy and dignity.

You have the right to make decisions about your health care, now and for the future. Medical treatment should only be given with your fully informed consent and you have the right to refuse treatment.

If, in the future, you become unable to express your choices for treatment, your doctors and family/friends may not know what you would want. ACP gives you the opportunity to think about, discuss and record, ahead of time, your choices.

An ACP *ONLY* comes into effect if you lose legal capacity to make decisions and express, in some way, your wishes and choices about your medical treatment.

Why is it important?

Up to 50% of Australians will not be able to make or express their own decisions when they are near death. Doctors and family members will be unaware of any treatment preferences at this time if these have not been discussed and recorded earlier.

Often, families are unaware of their loved one's views about what they would want done when too ill to speak for themselves. Families often feel burdened by the concern that they will make a wrong choice.

If there is not a clear statement of a person's wishes, doctors must treat them in the most appropriate way. This can mean aggressive treatments that the person might not have wanted.

What documents do I need?

The three ways you can record your choices these include:

1. **Enduring Power of Attorney (EPA)** - a legal document appointing a substitute decision maker of your choice.
2. **Advance Care Plan-Statement of Choices (ACP)** a guiding document outlining your wishes and preferences for future health care.
3. **Health Direction** a legal document with clear direction about refusal or withdrawal of treatment

Where do I register them?

It is important that you send **copies** all your documents to the ACT Health Advance Care Planning (ACP) Program. They will be scanned and placed on your electronic medical record at the Canberra Hospital and also Calvary Public Hospital. You may also like to give a copy to your GP and your attorneys (nominated substitute decision makers).

Need further information?

If you need assistance or would like more information please contact the Advance Care Planning Program, Clinical Quality and Safety Unit, 6205 3178 or email acp@act.gov.au.