ACT **Health**

Affix patient label or complete details

Name: ______________________

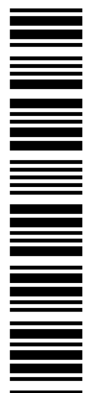
Address: ______________________

______________________ Phone: __________

DOB: __________ Sex: __________

URN: __________ (Hospital use only)

ADVANCE CARE PLAN STATEMENT OF CHOICES - NO LEGAL CAPACITY



Attorney under Enduring Power of Attorney/Guardian ***(please circle to identify which role)***

1. Name: ______________________

Telephone number(s) of Attorney:

______________________ (Home)

______________________ (Mobile)

______________________ (Work)

Relationship: ______________________

2. Name: ______________________

Telephone number(s) of Attorney:

______________________ (Home)

______________________ (Mobile)

______________________ (Work)

Relationship: ______________________

3. Name: ______________________

Telephone number(s) of Attorney:

______________________ (Home)

______________________ (Mobile)

______________________ (Work)

Relationship: ______________________

4. Name: ______________________

Telephone number(s) of Attorney:

______________________ (Home)

______________________ (Mobile)

______________________ (Work)

Relationship: ______________________

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

The following documents have been completed and are attached:

Enduring Power of Attorney or Guardianship Orders (as applicable): ☐ Yes ☐ No

Health Direction under 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 the 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. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

DO NOT WRITE IN THIS BINDING MARGIN

ADVANCE CARE PLAN STATEMENT OF CHOICES - NO LEGAL CAPACITY

This document relates to the following person: ______________________________

I understand that he/she has been assessed as not having legal capacity.

I have made choices based on the best interests of the person taking into account their wishes, the wishes of family members and significant others, and the benefits and burdens of treatment. I request that the stated choices recorded below are respected by health professionals now, and in the future.

Please note: The law requires that this statement be taken into account when determining treatment for this person.

1. Life Prolonging Treatments

Initial *the boxes you want and cross out the boxes you don't want.* You may write specific requests on the lines provided.

☐ **1.** I would like life prolonging treatments to be commenced and continued, including Cardio Pulmonary Resuscitation (CPR), while they are medically appropriate and remain in his/her best interests.

You may write specific requests here: ______________________________

____

____

____

Or

☐ **2.** If he/she is acutely ill, unable to communicate responsively with family and friends, and it is reasonably certain that he/she will not recover, I want him/her to be allowed to die naturally and be cared for with dignity. I do not want him/her to be kept alive by extraordinary or overly burdensome treatments that might be used to prolong his/her life (e.g. Cardio Pulmonary Resuscitation [CPR]). If any of these treatments have been started, I request that they be discontinued. However, I do want Palliative Care that includes medications and other treatments to alleviate suffering and keep him/her comfortable, and to be offered something to eat and drink.

You may write here specific treatment(s) that you want or don't want: ______________________________

____

____

____

____

____

2. Other requests with regard to medical care

e.g. Such as circumstances in which he/she does or does not want a particular treatment.

____

____

____

____

____

____

____

____

____

____

____

____

____

DO NOT WRITE IN THIS BINDING MARGIN

ADVANCE CARE PLAN STATEMENT OF CHOICES - NO LEGAL CAPACITY

Affix patient label or complete details

Name: ____________________

Address: ____________________

____________________ Phone: __________

DOB: __________ Sex: __________

URN: __________ (Hospital use only)

3. Other points that are important to the person

If the person had other end of life wishes, e.g. organ or body donation, you may wish to attach documentation to this plan. Please note: it is the next-of-kin/family that consent to organ donation.

I ask that doctors include the following persons in their health care decisions if there is time:

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

Signed by: ____________________ Date: __________

Attorney / Guardian (Please circle your relationship with the subject)

Other persons present at discussion and formulation of this plan:

Name	**Relationship**

Doctor's Review of the plan **Date:** __________

Doctor's name: ____________________

Doctor's signature: ____________________

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.