* 1 5 3 0 6 *

ACT Health

Advance Care Plan Statement of Choices - No Legal Capacity

Affix patient label or complete details

Name: _____

Address: _____

_____

DOB: _____ Telephone: _____

URN: _____(Hospital use only)

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 Donate Life register: ☐ Yes ☐ No

For more information about organ and tissue donation contact Donate Life on 6244 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. _____

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.

Affix patient label or complete details

Name: _____

Address: _____

_____

DOB: _____ Telephone: _____

URN: _____(Hospital use only)

ACT Health

Advance Care Plan Statement of Choices - No Legal Capacity

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: _____

Respecting Patient Choices® Advance Care Planning

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. This program is about the promotion 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 record, ahead of time, your choices in an Advance Care Plan.

An ACP *ONLY* comes into effect if you lose legal capacity to make decisions about your medical treatment.

Why is it important?

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.

Many people are now kept alive under circumstances that are not dignified and this can cause unnecessary suffering.

Where do I register them?

It is important that you send your Advance Care Plan documents to the ACT Health Respecting Patient Choices® (RPC) ACP Program, PO Box 11, WODEN ACT 2606. They will be scanned and placed on your electronic medical record at the Canberra Hospital.

Who can help me complete them?

Trained RPC ACP facilitators can assist you with completing the documents or introducing the subject with your family.

Please contact the Program if you would like to speak with a trained facilitator.

Need further information?

If you need assistance or would like more information please contact the Respecting Patient Choices Program, Health*CARE* Improvement Unit, 6244 3344 or rpc@act.gov.au.