* 1 5 3 0 5 *

Affix patient label or complete details

Name: _____

Address: _____

_____

DOB: _____ Telephone: _____

URN: _____

ACT Health

Advance Care Plan

Competent Person

Name of Attorney under Enduring Power of Attorney:

_____

Telephone number(s) of Attorney: _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Date: _____

If you choose to have an alternate donee:

Name of alternate Attorney under EPA: _____

Telephone number(s) of alternate Attorney: _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Date: _____

Your Advance Care Plan includes the following documents:

Enduring Power of Attorney: ☐ Yes ☐ No

Statement of Choices: ☐ Yes ☐ No

Health Direction under the Medical Treatment Act 2006: ☐ Yes ☐ No

Copies of your Advance Care Plan have been given to: *(complete as many lines as applicable)*

1. _____ 8. _____

2. _____ 9. _____

3. _____ 10. _____

4. _____ 11. _____

5. _____ 12. _____

6. _____ 13. _____

7. _____ 14. _____

Affix patient label or complete details

Name: _____

Address: _____

_____

DOB: _____ Telephone: _____

URN: _____

ACT Health

Statement of Choices

Competent Person

This Statement of Choices 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 decision-maker(s) and by my doctors. In addition I request that they respect my beliefs and values in life as we have previously discussed.

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

CPR (Cardiopulmonary Resuscitation) *Initial the box that you 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 a reasonable outcome*

*To me a reasonable outcome means:

_____

_____

_____

Life Prolonging Treatments *Initial the box that you 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

Or

☐ I only want life prolonging treatments **if** the doctors expect a reasonable outcome*

Or

☐ I wish to leave the decisions on life prolonging treatments to my Medical Enduring Power of Attorney (if appointed) or my person responsible in consultation with my doctors

Circumstances in which I would not want life-prolonging treatments include:

_____

_____

To me life prolonging treatments mean:

_____

_____

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 Respecting Patient Choices Consultant or doctor about this

My current medical condition includes: _____

_____

I wish to make the following further requests regarding my treatment: _____

_____

_____

_____

Other points that are important to me

I ask that my Medical Enduring Power of Attorney include the following persons 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):

_____

_____

_____

_____

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

_____

_____

_____

_____

If you have other end of life wishes, e.g. organ or body donation, you may wish to attach your documentation to this plan. NB. It is important to register as a donor and discuss your wishes with your next-of-kin/family. (ACT Organ and Tissue Donation: (02) 6244 2222)

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 1 signature _____ Date_____

Witness 1 name _____ Relationship _____

Witness 2 signature _____ Date_____

Witness 2 name _____ Relationship _____