AlfredHealth

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit:……

UR:

Family Name

Given Names

Date of Birth

Gender: ☐ Male ☐ Female

ADVANCE CARE PLAN

I, _____ DOB: _____

(*Given Name/s* *Family Name)*

understand that my Advance Care Plan will only be used to guide future medical decisions, if I am unable to make decisions for myself. I understand that it is important to discuss my wishes with my Medical Enduring Power of Attorney, the people closest to me and my health care team so they are aware of my choices. I understand that my doctors can only offer treatments that are medically appropriate and request that my values and beliefs are considered when determining medical treatment in the future.

I would like the following person to be responsible for consenting to medical decisions on my behalf if I am unable to make my own decisions:

Name: _____ Relationship: _____

Phone Number: _____

I have formally appointed them as my Medical Enduring Power of Attorney and completed the required document (this is recommended)

☐ Yes *(attach a certified copy)* ☐ No

1. What matters to me:

(Think about what is most important to you, what do you value most, what can you not imagine living without)

2. To me "living well" means:

(E.g.: *talking with my family and friends, eating, watching TV, discussing current events, faith-based beliefs, managing my own personal care needs, being mobile).*

3. My current health problems include:

(List any current health issues here and describe how they affect your quality of life).

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4. Unacceptable Circumstances:

(Please describe any circumstances where you would prefer the goal of care to be about making you comfortable, rather than trying to prolong your life. E.g.: If I couldn't communicate or recognise my family, If I was bed bound and needed to rely on others to feed me and take me to the toilet).

Questions about specific medical treatments are best discussed with a health care professional

5. Health Care Goals and Life Prolonging Treatments

If I became unwell and couldn't communicate with the doctors, I would like the following care:
(E.g. If I was to suffer a stroke, heart attack or accident)

Initial in the chosen box below:

☐ I would like life prolonging treatment that is suitable for my medical condition – in order to prolong life as long as possible.

OR

☐ I would like all life prolonging treatments that are on offer until my level of recovery is known. However, if my health outcomes reflect my unacceptable circumstances I would want treatment withdrawn. ***(I have listed my unacceptable circumstances above).***

OR

☐ I would like doctors to provide treatments that are aimed at relief of pain and distressing symptoms only. I do not want death prolonged by medical interventions. Keep me comfortable and allow nature to take its course.

In the event that I stop breathing, or that my heart stops beating, my wish with Cardiopulmonary Resuscitation (CPR) is;

Initial in the chosen box below:

☐ **I want** Cardiopulmonary Resuscitation (CPR) attempted if medically appropriate.

OR

☐ **I do NOT want** Cardiopulmonary Resuscitation (CPR) attempted – please allow a natural death.

Other requests about my medical treatment:

*** If you wish to refuse medical treatment/s for a current condition you can complete a legally binding Refusal of Treatment Certificate. Please discuss with your treating doctor**.

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6. If I am nearing death the following things would be important to me:

(E.g.: I would prefer to receive care where I am living or I would prefer to be transferred to hospital, I would like to have family present, any cultural or spiritual beliefs, music or photos that are important)

7. Other wishes after death:

I am supportive of organ and tissue donation: ❑ Yes ❑ No

Declaration by competent person

I ……..…….. declare that the information completed above is a
(Given Name/s Family Name)
true record of my wishes on this date. I have read and understand the importance of this document.

My signature ……..…… Date: ..... / ..... / .....

Witness signature ……..…… Date: ..... / ..... / .....
(Preferably Medical Enduring Power of Attorney or someone close to you)

Witness name …… …… Relationship ……

Doctors' Declaration

I, Dr……..…… have discussed with
(Doctor's name)
…….. his / her decisions for future medical
(Person's name)
treatment/s that are expressed in this document. I believe this person is of sound mind, is making these decisions voluntarily and understands their consequences.

Dr Signature..…….. Date: ..... / ..... / .....

Review

It is recommended that an Advance Care Plan is reviewed, and updated / re-written if necessary, every year, or when there is a change in personal or medical situations

Date of review and / or update	Signature

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