

Alfred Sandringham Caulfield

Unit:.....

ADVANCE CARE PLAN For the Non Competent Person

UR:

Family Name

Given Names

Date of Birth

Gender: Male Female

This Advance Care Plan applies to: , _____
(Given Name/s Family Name)

Date of Birth: : : Address: _____

This Advance Care Plan is being completed by: _____
(Family Name Given Name/s)

Relationship to Person: _____ Ph Number: _____

I am formally appointed as the Medical Enduring Power of Attorney

Yes (certified copy must be attached) No

This plan relates to the above person. I understand that he/she has been assessed as not having the capacity to make medical decisions independently.

I understand that this plan is not a legally binding document, but a guide that will be taken into account when determining treatment for this person. I understand that doctors will only offer treatments that are medically appropriate and beneficial.

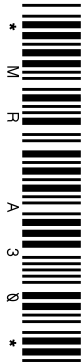
I have completed this plan based on my knowledge of this person and their values, beliefs and preferences.

1. The things that matter most:

(What is most important to him/her, what does he/she value most, what would 'living well' mean to him/her)

2. Current health problems include:

(List any current health issues here and describe how they affect his/her quality of life)



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3. Unacceptable Circumstances:

(Please describe any circumstances where you believe the person would prefer the goal of care to be about making him/her comfortable rather than trying to prolong life. E.g.: not being able to communicate clearly or recognise friends/family, being bed bound and relying on others for feeding, bathing and toileting).

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

4. Health Care Goals and Life Prolonging Treatments

The preference for care if he/she becomes unwell now;

Initial in the chosen box below:

Provide all life prolonging treatments that are suitable for his/her medical condition – in order to prolong life as long as possible.

OR

Provide life prolonging treatments that are on offer for him/her until the level of recovery is known. However, if the health outcome reflects the unacceptable circumstances (*listed above*) withdraw treatment.

OR

Keep him/her comfortable and allow a natural death. Only provide treatments that are aimed at relieving pain and distressing symptoms.

In the event that he/she stops breathing or that his/her heart stops beating;

Initial in the chosen box below:

Attempt Cardiopulmonary Resuscitation (CPR) if medically appropriate.

OR

Do NOT attempt Cardiopulmonary Resuscitation (CPR) – please allow a natural death.

Other requests about medical treatment:

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5. If he/she is nearing death the following things would be important:

(E.g.: Preferred location of treatment, who you believe they would like present, any cultural or spiritual beliefs, music or photos that are important)

6. Other wishes after death:

He/she is supportive of organ and tissue donation: Yes No

Declaration

I have made choices in the best interests of _____
(Non-competent person's Given name & Family Name)
taking into account his/her wishes, the wishes of family members and significant others, and the benefits and burdens of treatment.

Name: _____
(Given Name/s Family Name)

Signature: _____ Date: / /

Relationship to person _____ MEPOA Person Responsible

I, Dr _____ believe that _____
(Doctors name) (Person making Declaration)

is acting in the best interests and on behalf of the person stated above and understands the importance and implications of this document.

Doctor's 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