AlfredHealth

UR:

Family Name

Given Names

Date of Birth

Gender:

☐ Male ☐ Female

☐ Alfred ☐ Sandringham ☐ Caulfield

Unit:……

# ADVANCE CARE PLAN
## For the Non Competent Person

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)*

_____

_____

_____

_____

_____

_____

_____



Date Created: May 2015
**Printed From Intranet**

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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 |
|---|---|
| | |
| | |
| | |
| | |



Date Created: May 2015
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