



* 1 5 3 0 5 *

ACT Health

Advance Care Plan Statement of Choices - Competent Person

Affix patient label or complete details

Name: _____

Address: _____

DOB: _____ Telephone: _____

URN: _____(Hospital use only)

Name of Attorney(s) under Enduring Power of Attorney

1. Name: _____

2. Name: _____

Telephone number(s) of Attorney:

Telephone number(s) of Attorney:

_____ (Home)

_____ (Home)

_____ (Mobile)

_____ (Mobile)

_____ (Work)

_____ (Work)

Relationship: _____

Relationship: _____

3. Name: _____

4. Name: _____

Telephone number(s) of Attorney:

Telephone number(s) of Attorney:

_____ (Home)

_____ (Home)

_____ (Mobile)

_____ (Mobile)

_____ (Work)

_____ (Work)

Relationship: _____

Relationship: _____

Date of the Enduring Power of Attorney (EPA): _____

The following documents have been completed and are attached:

Enduring Power of Attorney: Yes No

Advance Care Plan: Yes No

Health Direction under the 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 my 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. _____

4. _____

2. _____

5. _____

3. _____

6. _____

This Advance Care Plan 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 attorney(s) and by my doctors. In addition I request that they respect my values and wishes as we have previously discussed.

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

Living well, or an acceptable recovery/reasonable outcome after illness or injury can mean:

(Example: To be able to communicate meaningfully with family/friends; not be completely bed bound; to not be dependent on others for personal hygiene; to be able to eat and drink naturally; to have some mobility)

*To me 'living well' or an acceptable recovery/reasonable outcome means (please write what is important to you):

My Choices About Life Prolonging Treatments *Initial the box that you want and put a line through the boxes that you do not 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.
Circumstances in which I would not want life-prolonging treatments include:

To me life prolonging treatments mean:

Or

I only want life prolonging treatments if the doctors expect an acceptable recovery/reasonable outcome as described above.*

Or

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

My choices about treatment if my heart stops or there are no signs of life (not moving, unresponsive, not breathing, unconscious).

CPR (Cardiopulmonary Resuscitation) can be attempted to restart a heart.

CPR (Cardiopulmonary Resuscitation) *Initial the box that you want, put a line through the boxes that you do not want.*

I am willing to have CPR in an attempt to restart my heart

Or

I **do not** want CPR at all

Or

I **only want** CPR if the doctors expect an acceptable recovery/reasonable outcome as described above.*

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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 Facilitator or doctor about this

(Complete if applicable)

My current medical condition (include any chronic condition or life limiting illness) _____

I wish to make the following further requests regarding my treatment for the conditions described above: _____

Other points that are important to me

I ask that my Enduring Power of Attorney(s) include the following people 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, e.g. care of a pet, religious practices, spiritual leaders, pastoral care):

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

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 signature _____ Date _____

Witness name _____ Relationship _____

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.

There are three ways to record your healthcare choices:

1. Enduring Power of Attorney (legal document)
2. Statement of Choices (record of wishes and values regarding future medical treatments – non legal document)
3. Health Direction under the Medical Treatment (Health Directions) Act 2006 (legal document)

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, HealthCARE Improvement Unit, 6244 3344 or rpc@act.gov.au.