BCH Bass Coast Health

Advance Care Plan (Statement of Health Choices)

Surname ..... U.R. No. .....

First Name ..... Sex .....

PATIENT LABEL

Date of Birth ..... Age .....

Doctor ..... Ward .....

I made this Advance Care Plan after I discussed it with my doctor _____ .
(insert name)

This Plan replaces any previous plan that I may have made before. I understand that my values and beliefs may be different from the people I choose to make decisions for me (substitute decision maker). I ask them to make the decisions which I would make. I also understand that if necessary I can change my Advance Care Plan at any time.

Why? Have your voice heard	It is good to think about your future health care needs and to discuss these with others. If a time comes when you are unable to make your own decisions, the law makes sure that you will be represented by someone appointed by you, your primary carer, your closest relative, or a Tribunal. You can help the person you have chosen to represent you by telling them what would be important to you at this stage in your life. This document suggests some of the issues you might like to discuss with both your doctor and the person you have chosen to represent you. The document is in two parts: in the first you can choose up to 2 people who you trust to speak on your behalf. In the second part, you can directly express the views that are important to you. You may complete all or part of these sections.
Me About me	My Name: _____ My Date of Birth: ____/____/____ My address: _____
Who? Who could speak for me?	The people I have chosen to make medical decisions for me may include my Medical Agent, Next of Kin, Carers, or a Guardian if appointed and other persons I trust. The people I have chosen to make decisions for me and be responsible for consenting for medical decisions on my behalf if I am unable to make my own decisions will be in order of my preference or in accordance with the law: **Attach copies** of current Powers of Attorney documents – Medical and Guardianship. Please let staff know if you do not have a substitute decision maker.

Person 1				
Name:				
Address:				
Phone:	Home:		Mobile:	
Relationship to me:				
I have formally appointed them as my Enduring Power of Attorney (medical treatment) and completed the forms (this is recommended)	☐ YES ☐ NO			
Person 2				
Name:				
Address:				
Phone:	Home:		Mobile:	
Relationship to me:				
I have formally appointed them as my Enduring Power of Attorney (medical treatment) and completed the forms (this is recommended)	☐ YES ☐ NO			

Initial: _____

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What? What is important to me

Here you can say what is important to you.

Please think about what you would like to do about your health care and talk to your doctor about this before signing this plan.

My Beliefs & Values

1. **My** current health problems include:

_____

_____

_____

_____

2. What is difficult for **me** to do **now** because of my health conditions?

_____

_____

_____

_____

3. What worries me about what will happen to my **health in the future** and what that may mean for me?

_____

_____

_____

_____

4. The following things worry or concern me **unrelated** to my health: (include family concerns, hopes and fears, emotional issues, accommodation, people I do/not want involved etc.)

_____

_____

_____

_____

5. We are all unique and often have different beliefs, values and goals. What does it mean to you to "**live well**"? These are the things in life that are most important and have a lot of meaning for me.
For example: enjoying activities, spiritual or religious beliefs, pets, family and friends, watching TV, independence.

_____

_____

_____

_____

_____

Initial: _____

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6. Life is unpredictable and it is almost impossible to know what will happen to our health in the future. The following things are important to **me** and they may help my substitute decision maker to make medical decisions in the future for me: (For example treatments I would not want, special religious or cultural care.)

_____

_____

_____

_____

For me too burdensome treatments or an outcome I would find unacceptable include:

_____

_____

_____

7. If I have an illness or injury which is so serious that I cannot speak for myself, I would like to choose: (Please tick one box only and sign and date)

☐ I would like life prolonging treatments that are suitable for my medical condition/injury

Sign: _____ Date: ____/____/_____

OR

☐ I want to be kept comfortable and be provided with treatments that are not distressing and mainly aimed at relief of pain and other symptoms.

Sign: _____ Date: ____/____/_____

Comment: _____

_____

8. If I am not breathing and am unresponsive, my wish with Cardiopulmonary Resuscitation (CPR) is: *(tick appropriate box below)*

☐ Attempt resuscitation if clinical indicated

OR

☐ **DO NOT** attempt resuscitation

CPR usually involves compressions to the chest which sometimes result in broken ribs, needles and tubes to administer fluids and/or drugs, and a tube placed in the throat to assist breathing. These interventions may or may not restore life.

Comment:_____

_____

_____

Please note this is a guide only, there is a separate Limitation of Medical Treatment and Refusal of Treatment forms that can be discussed and completed on in-patient admission. Your health at that time can be considered.

9. Other things that are important to me are:

_____

_____

10. I am a registered ☐ Organ and/or ☐ Tissue Donor Donor Number: _____

Initial: _____

ADVANCE CARE PLAN (STATEMENT OF HEALTH CHOICES) ORG-110

Bass Coast Health

Advance Care Plan (Statement of Health Choices)

Surname ..... U.R. No. .....

First Name ..... Sex .....

PATIENT LABEL

Date of Birth ..... Age .....

Doctor ..... Ward .....

Signatures and Witnessing

Declaration by competent person:

This is a true and correct record of my healthcare wishes and preferences for a future time when I can no longer make decisions for myself. I consent to a copy of this My Advance Care Plan – Statement of Health Wishes to be provided to relevant health care providers.

Print Name: _____

Signature: _____ Date: ____/____/____

Declaration by Medical Doctor:

I, Dr. _____, witness that this person

_____,is competent to meaningfully complete this Advance Care Plan and understands the importance and implications of this Advance Care Plan. I have given this person the opportunity to discuss with me the benefits and the burdens of potential treatments and to clarify issues about their medical treatment options, including the refusal of treatment. I am satisfied this is a valid Advance Care Plan.

Doctor's Signature: _____ Date: ____/____/____

(Optional second)

Witness name (Print): _____

[Preferably substitute decision maker / Enduring Power of Attorney (Medical Treatment)]

Witness' Signature: _____ Date: ____/____/____

Sharing of your Advance Care Plan by competent person:

I understand that it is important to discuss these healthcare preferences with my GP, local hospital and my family / friends, including my substitute decision maker (usually Enduring Power of Attorney (medical treatment)– if appointed. I have discussed and provided a copy of My Advance Care Plan – Health Wishes to the following people:

Name	Contact Phone Number

It is recommended that an Advance Care Plan is reviewed every year or when there is a change in personal or medical situations. If it needs to be altered or changed we recommend you complete a new My Advance Care Plan – Statement of Health Wishes form and provide copies of the new form to your substitute decision maker, family, GP and Bass Coast Health.

Reference: St. Vincent's Hospital, 11/14, 'My Advance Care Plan – Health Wishes (SV001049)'