WEST GIPPSLAND HEALTHCARE GROUP

Advance Care Plan

Surname: .....

Given Names: .....

Date of Birth: .....Sex: .....

UR No: .....

(AFFIX PATIENT LABEL HERE)

If I am unable to speak for myself, this is an Advance Care Plan for:

Full Name: .....

Date of Birth: .....

Address: .....

.....

Completed by: ☐ myself

Or ☐ (Name / relationship) .....

Current health problems include: .....

.....

.....

- I understand that it is important to talk about my healthcare choices with my Doctors, and my family / friends, including the Medical Enduring Power of Attorney (if appointed).
- I request that these preferences, and the beliefs and values on which they are based are respected.
- I understand the importance and purpose of this document. I may fill in all or part of this document. It is a guide for future medical treatment, and will be taken into account when working out the best treatment for me.

☐ **I have appointed a Medical Enduring Power of Attorney:**

Full Name: .....

Relationship: .....

Contact Number/s: .....

OR

☐ **I have NOT appointed a Medical Enduring Power of Attorney**, but 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:

Full Name: .....

Relationship: .....

Contact Number/s: .....

<u>Please forward a copy of your completed Advance Care Plan to</u>:
Medical Records, West Gippsland Healthcare Group,
41 Landsborough Street, WARRAGUL VIC 3820

Name: ..... Signature.....Date:.....

Emergency directions - see page 3

Version 4 – March 2017 – Internal printing until trial completed

WEST GIPPSLAND HEALTHCARE GROUP

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Surname:.....

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(AFFIX PATIENT LABEL HERE)

My Values and Beliefs

The things that I most value in life are: *(for example: independence, enjoyable activities, talking to family and friends, spiritual or religious beliefs, pets)*

I would like the following concerns to be considered when making future medical decisions: *(what are your worries / fears, what compromises are you willing to make)*

If unable to be cared for at home, the following would be important

If nearing death, the following would be important: *(eg music, spiritual care, customs or cultural beliefs, family present)*

Other wishes after death

I am a registered ☐ organ and ☐ tissue donor Donor Number: .....

Other: .....

Name:..... Signature.....Date:.....

Emergency directions - see page 3

WEST GIPPSLAND HEALTHCARE GROUP

Advance Care Plan

Surname:.....

Given Names:.....

Date of Birth:..... Sex: .....

UR No:.....

(AFFIX PATIENT LABEL HERE)

Emergency directions

sign your name and date in each relevant box

Signature:

Date:

I would like life prolonging treatment that are suitable for my medical condition / injury. Other comments:

.....

.....

However, I do not want treatments that would be too difficult to cope with or likely to result in an ongoing health burden. For me, treatments or an outcome I would find unacceptable include:

.....

.....

.....

.....

.....

OR

Signature:

Date:

I would like doctors to provide treatments that are non-burdensome and mainly aimed at relief of pain and other symptoms. When dying, please allow me to die naturally and do not prolong my dying by medical interventions, except those for the relief of symptoms and suffering.
Other comments:

.....

.....

.....

.....

.....

Signature:

Date:

If required and appropriate **I would like** Cardiopulmonary Resuscitation (CPR) attempted.

Signature:

Date:

I do NOT want Cardiopulmonary Resuscitation (CPR) if I am unresponsive and not breathing normally.

WEST GIPPSLAND HEALTHCARE GROUP

Advance Care Plan

Surname:.....

Given Names: .....

Date of Birth: ..... Sex:.....

UR No: .....

(AFFIX PATIENT LABEL HERE)

This is a true record of **my** healthcare preferences on this date.

Full Name: .....

Signature: ..... Date: .....

Witness' Name *(Print)*: .....

(preferable *substitute decision maker / medical enduring power of attorney)*

Witness' Signature: ..... Date: .....

I, Dr ..... believe that .....

(Registered Medical Practitioner) *(Name)*

is competent and understands the importance and implications of this document.

Doctor's Signature: ..... Date: .....

The contents of this Advance Care Plan have also been discussed with:

Name	.....	Name	.....
Relationship	.....	Relationship	.....
Signature	.....	Signature	.....
Date	.....	Date	.....
Name	.....	Name	.....
Relationship	.....	Relationship	.....
Signature	.....	Signature	.....
Date	.....	Date	.....

The following people/institutions have a copy of my Advance Care Plan:

- ☐ GP Clinic .....
- ☐ Residential Care Facility .....
- ☐ WGHG
- ☐ Medical Enduring Power of Attorney
- ☐ Other: .....

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

Date or Review and / or update	Signature

Name:..... Signature.....Date:.....

Emergency directions - see page 3