tō tātou reo advance care planning

Summary of my Advance Care Plan

Please return your completed "Summary of my Advance Care Plan" form to your GP Practice who will upload a copy to your personal health care record at Waikato Hospital.

ADVANCE CARE PLAN

1. This is my advance care plan summary and contains my choices. Please follow this plan if I am unable to tell you what I want.

Full name: _____

Date of birth: _____ NHI number: _____

Address: _____

2. What matters to me

This is what I want my family/whānau and loved ones and healthcare team to know about who I am and what matters to me:

3. What worries me

This is what I want my family/whānau, loved ones and healthcare team to know about what worries me:

4. Why I'm making an Advance Care Plan

This is why I am making an Advance Care Plan: _____

I am receiving care and treatment for the following: _____

If my time were limited my priorities would be: _____

Emergency directions - see page 3

We acknowledge the collaborative work of the Midland Regional ACP Facilitators Group in the development of this document (2017/8)

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Summary of my Advance Care Plan
- continued

Patient details

Name: _____

NHI: _____ DOB: _____ dd/mm/yy

ADVANCE CARE PLAN

5. If I am unable to make decisions:

If I am unable to make decisions, I would prefer them to be made like this:

I want my activated enduring power of attorney (EPA) for personal care and welfare to make decisions using the information in this summary of my advance care plan.

I have discussed my future care and treatment options with them ☐ Yes ☐ No

My EPA's name is: _____

Relationship to me: _____

Mobile: _____ Other phone: _____

OR

☐ I don't have an enduring power of attorney.

Using the information in this summary of my advance care plan, the following person will help my healthcare team make the best decisions for me:

Name: _____ Relationship: _____

Mobile: _____ Other phone: _____

In addition, the following people know me well and understand what is important to me. I would like them included in discussions about my care and treatment

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

6. If I am dying

If I am dying I would prefer to be cared for in this place: _____

OR

☐ I don't mind where I am cared for ***(tick if this applies)***

7. My cultural, religious and spiritual values, rituals and beliefs:

Emergency directions - see page 3

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Summary of my Advance Care Plan
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Patient details

Name: _____

NHI: _____ DOB: _____ dd/mm/yy

8. Emergency directions - My treatment and care choices if I am unable to make decisions for myself

This section is best completed with help from a doctor, nurse or specialist.
The following best describes the care I would like to receive. I understand this does not require the healthcare team to provide treatments which will not be of benefit to me.

Choose only ONE of these options below.

A

I would like my treatment to be aimed at keeping me alive as long as possible. I wish to receive all treatments that the health-care team think are appropriate to my situation.

The exceptions to this would be:

If required and appropriate I would want CPR to be attempted:

☐ Yes ☐ No

☐ I will let my doctor decide at the time.

Signature

Date dd/mm/yy

OR

B

I would like my treatment to focus on quality of life.
If my health deteriorated I would like to be assessed and given any tests and treatments that may help me to recover and regain my quality of life, but I DO NOT WANT TO BE RESUSCITATED.

For me quality of life is:

Signature

Date dd/mm/yy

OR

C

I would like to receive only those treatments which look after my comfort and dignity rather than treatments which try to prolong my life. I DO NOT WANT TO BE RESUSCITATED.

Signature

Date dd/mm/yy

OR

D

I cannot decide at this point. I would like the healthcare team caring for me to make decisions on my behalf at the time, taking into account what matters to me and in close consultation with the people I have listed in Number 5.

Signature

Date dd/mm/yy

OR

E

None of these represent my wishes. What I want is documented on my Advance Directive which is attached.

☐ Advance Directive completed and attached

Signature

Date dd/mm/yy

ADVANCE CARE PLAN

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- continued

Patient details

Name: _____

NHI: _____ DOB: _____ dd/mm/yy

ADVANCE CARE PLAN

9. Signatures

By signing below, I confirm:

- I understand this is a record of my preferences to guide my healthcare team in providing appropriate care for me when I am unable to speak for myself
- I understand treatments that would not benefit me will not be provided even if I have specifically asked for them.
- I agree that this advance care plan can be in electronic format and will be made available to all health-care providers caring for me.

Name: _____ Signature: _____

Date: _____ Phone: _____
dd/mm/yy

Healthcare professional who assisted me

By signing below the healthcare professional confirms that:

- I am competent at the time I created this advance care plan.
- We discussed my health and the care choices I might face.
- I have made my advance care plan with adequate information.
- I made the choices in my advance care plan voluntarily.

Healthcare professional: _____ Designation: _____

Facility/organisation: _____

Signature: _____ Date: _____
dd/mm/yy

I understand that it is important to discuss these healthcare preferences with my GP, local hospital and my family/whānau/friends, including my substitute decision maker (usually medical enduring power of attorney if appointed). I have discussed and provided a copy of my advance care plan to:

☐ GP ☐ Local hospital

☐ EPA ☐ Family/whānau/friend (name) _____

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 summary of my advance care plan form and provide copies of the changes to your substitute decision maker, family/whānau, GP and local hospital.

Emergency directions - see page 3

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