*Attach patient label here*

**Summary of my Advance Care Plan**

**VERSION NUMBER:** # **(Click to open drop down box)**

***Please file in front of Patient’s Records***

|  |  |  |
| --- | --- | --- |
| **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** | | Advance Care Plan |
| **Full Name:** | |
| **Address:** | |
| **Date of Birth:** | **NHI Number:** |
| **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:** | |
| **5. My cultural, religious and spiritual values, rituals and beliefs:** | |
| **6. 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)** | |

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| Advance Care Plan | **7. If I am unable to make decisions**:  **I would prefer them to be made like this:**  **I want my activated Enduring Power of Attorney 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** | | | | | | | | |
| **8. The name of my Enduring Power of Attorney (EPOA) is**: | | | | | | | | |
| **Relationship to me**: | | | | | | | | |
| **Mobile:** | | | | | **Other Phone**: | | | |
| **Or**  **I don’t have an Enduring Power of Attorney (EPOA)** | | | | | | | | |
| **9. 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:** | |
| **10. 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:** | | | | |
| **I like to know:**  **11.** | | | | | | | | |
| only the basics |  |  |  | |  |  |  | all the details about my condition and treatment |
| **As doctors treat me I would like…** | | | | | | | | |
| my doctors to do what they think best |  |  |  | |  |  |  | to have a say in every decision |
| **If I had an illness that was going to shorten my life, I prefer to…** | | | | | | | | |
| know my doctor’s best estimate for how long I have to live |  |  |  | |  |  |  | Not know how quickly it is likely to progress |
| **How involved do you want your loved ones to be?** | | | | | | | | |
| I want them to do exactly as I have said, even if it makes them uncomfortable |  |  |  | |  |  |  | I want them to do what brings them peace, even if it goes against what I have said |
|  | | | | | | |
| **When it comes to sharing information…** | | | | | | | | |
| I don’t want my loved ones to know anything about my health |  |  |  | |  |  |  | I am comfortable with my loved ones knowing everything about my health |

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| **12. 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 five options below. You may wish to **DELETE / CROSS OUT** the others | | Advance Care Plan |
| *Signature* | **I would like my treatment to be aimed at keeping me alive as long as possible.** I would want full efforts to prolong my life, including efforts to restart my heart if it stops beating. |
| *Date* |
| **OR:**  *Signature* | **I would like to receive treatments to prolong my life, but if my heart stops beating or I can’t breathe on my own then do not shock my heart to restart it (Do Not Resusitate) and do not place me on a breathing machine.** Instead, if either of these happens, allow me to die peacefully. Reason why: if I took such a sudden turn for the worse then my condition would likely be worse if I survived, and this would not be an acceptable quality of life for me. |
|  |
| *Date* |
| **OR:**  *Signature*  *Date* | **I would like to only receive care in the place where I am living. I would not want to go to the hospital even if I were very ill.** If a treatment, such as antibiotics, might keep me alive longer and could be given in the place where I am living, then I would want such care. But if I continued to get worse, I would not want to go to an emergency room or a hospital. Instead, I would want to be allowed to die peacefully. Reason why: I would not want the possible risks and trauma which can come from being in the hospital. |
| **OR:**  *Signature*  *Date* | **I would like to receive comfort-oriented care only, focused on relieving my suffering such as pain, anxiety, or breathlessness.** I would not want any care that would keep me alive longer. |
| **OR:**  *Signature*  *Date* | **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 7** |

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| Advance Care Plan | **13. Signatures**  **• 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 healthcare providers caring for me.** | |
| **Name:** | **Signature:** |
| **Date:** |
| **Phone:** |
| **14. 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 Practitioner:Designation: | |
| Facility/Organisation: | |
| Signature: | Date: |
| **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 (Name)  Local hospital**  **EPOA  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 the Advance Care Plan form, stating which Version Number it is, and provide copies of the changes to your substitute decision maker, family/whānau, GP and local hospital.** | |

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| My Advance Directive | | | |
| **In the following circumstances:** | **I would like my care to focus on:** | **I would accept the following treatments:** | **I would wish to refuse or stop the following treatment:** |
| *Example: Severe stroke, unable to recognize anyone* | *Example: Allowing a natural death* | *Example: Comfort measures* | *Example: Artificial feeding* |
|  |  |  |  |
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