



Resident Label:
Date Completed ____/____/20__

Advanced Care Plan

COPY OF ENDURING GUARDIAN ATTACHED: YES / NO

This Advanced Care Plan is to be reviewed, Confirmed and Documented in the event of significant deterioration of a resident (and at least annually). Review is to be in conjunction with the Resident Named, Person responsible / Enduring Guardian as nominated, Medical Practitioner and Registered Nurse. This is not a legal document and can be amended at any time.

If I am unable to speak for myself, I authorise you to consult with the following about my health concerns and medical condition with the people below and/or my doctor.

I have appointed the following:

	YES / NO	Name, contact numbers and relationship
Enduring Guardian (Health decisions)		
Medical Practitioner		
Next of Kin / Person Responsible		

1. Have you discussed or do you wish to discuss with the Medical Practitioner and or Person responsible / Guardian / Registered Nurse to discuss your wishes? Yes NO
2. In the event of a life threatening episode do you want Cardio Pulmonary Resuscitation (CPR)? Yes NO
3. In the event of a life threatening episode do you want a hospital transfer? Yes NO
4. In the event of a life threatening episode do you want to be treated by IV or Oral Antibiotics? Yes No

5. Do you wish us to contact your nominated person if we believe you are approaching end of life? Yes NO
6. Do you want us to notify a minister of religion and/or spiritual support called?
 o Approaching end of life
 o After Death o Neither
7. Is there any bequest in place for research of organs Please provide relevant documentation if answering yes. Yes NO
8. Are there any special considerations for my body before or after death? Please provide details if answering yes. Yes NO

CURRENT STATE OF HEALTH:

<i>In your own words – can you tell us what concerns you most about your health at the moment?</i>

PERSONAL VALUES AND BELIEFS:

<i>What are the things that matter most to you? (e.g. family and friends, familiar activities, independence, spiritual beliefs, religious practices, cultural beliefs)</i>

FUTURE HEALTH SITUATIONS:

If I am not expected to recover, or my quality of life has become unacceptable of me as indicated in my personal values, then I do not give consent to the following treatments:

- 1. *Artificial ventilations through a tube (also known as “Life support, Breathing machine”*
- 2. *Renal dialysis (Kidney function replacement)*
- 3. *Artificial feeding or hydration (e.g. Intravenous fluids)*
- 4. *Other please list any additional below.*

GOALS FOR END OF LIFE CARE:

- 1. *Keep me comfortable*
- 2. *Take out tubes and lines that are not adding to my comfort*
- 3. *Let my family and friends be with me*
- 4. *Offer me something to eat and drink for comfort*
- 5. *Stop medications that do not add to my comfort*
- 6. *Attend to my spiritual needs*
- 7. *Allow me to be cared for within familiar surroundings*
- 8. *Other:* _____

Funeral Arrangements

Please note we require this information to be completed, if you do not have a preferred provider one can be allocated until such time as arrangements have been made.

I / we wish to use the following funeral provider:

Name: _____

Address:

Telephone: _____

I / we do **not** currently have a preferred funeral provider and would like to have one appointed.

I / we understand that this arrangement can be amended at any time, should I / we wish to appoint our preferred provider. Details of which will be provided to the facility at this time.

Signed: _____

Date: _____

DECLARATION BY RESIDENT	
I,	(witness)
(print name)	Relationship:
Declare that the information completed above is a true record of my wishes on this date.	Witness Name:
Signature:	Witness Signature:
Date:	Date:

OR

DECLARATION BY ENDURING GUARDIAN OR PERSON NOMINATED	
I,	(witness)
(print name)	Relationship:
Declare that the information completed above is a true record on this date.	Witness Name:
Signature:	Witness Signature:
Address:	
Phone:	
Date:	Date:

Next Review detail

Discussed date: _____ Staff: _____

Resident or Substitute decision maker: _____

Discussed date: _____ Staff: _____

Resident or Substitute decision maker: _____

