Surname: ..... NHI: .....

First Names:.....

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

Phone:…….. Mobile:……

My Advance Care Plan

For full 'My Advance Care Plan & Guide' see http://www.advancecareplanning.org.nz/assets/My_Advance_Care_Plan.pdf

1. WHAT MATTERS TO ME

This is what I want my whānau, loved ones and healthcare team to know about who I am and what matters to me *(eg. what makes you happy, what makes life meaningful, how do you like to spend your time)*

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

To honour these beliefs I want my whānau, loved ones and healthcare team to:

2. WHAT WORRIES ME

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

☐ **my loved ones because**:

☐ **suffering. To me this means**:

☐ **not being able to talk or communicate**.

☐ **not doing things such as**:

☐ **other things that worry me are**:

or

☐ **nothing worries me**

3. WHY I AM MAKING AN ADVANCE CARE PLAN

This is why I am making an advance care plan:

I am receiving care and treatment for the following:

I understand this may happen to my health in the future:

Facing my future makes me think about:

Facing my future makes me feel:

Surname: ..... NHI: .....
First Names:.....
Date of Birth: ..... /..... /..... Sex: .....
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If time were limited my priorities would be:

4. HOW I MAKE DECISIONS

I like to know….						
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

IF I AM UNABLE TO MAKE DECISIONS

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

My EPA's name is:_____

Relationship to me:_____PHONE:_____

OR

☐ I don't have an enduring power of attorney. Using the information in this advance care plan, the following person will help my healthcare team make the best decisions for me.

Name:_____

Relationship to me:_____PHONE:_____

Surname: ..... NHI: .....
First Names:.....
Date of Birth: ..... /..... /..... Sex: .....
Phone:…….. Mobile:……

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 to me:_____PHONE:_____

Name:_____

Relationship to me:_____PHONE:_____

Name:_____

Relationship to me:_____PHONE:_____

5. WHEN I AM DYING

As I am dying, my quality of life means:

Other details I would like you to know:

I understand that when I am dying my comfort and dignity will always be looked after:
This will include food and drink if I am able to have them.
In addition, I would like you to:

☐ Let the people who are important to me be with me.

☐ Take out thing, like tubes, that don't add to my comfort.

☐ Stop medications and treatments that don't add to my comfort.

☐ Attend to my religious, cultural and/or spiritual needs

The place I die is important to me: ☐ YES ☐ NO

When I am dying I would prefer to be cared for:

☐ at home, which for me is: _____

☐ in hospital

☐ in a hospital level care facility (residential care)

☐ in hospice

☐ I don't mind where I am cared for

Other details I would like you to know:

Surname: ..... NHI: .....
First Names:.....
Date of Birth: ..... /..... /..... Sex: .....
Phone:…….. Mobile:……

6. MY TREATMENT & CARE CHOICES

This section is best completed with help from a doctor, nurse or specialist.

If I am seriously ill and I am unable to make decisions for myself, 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.

Seriously ill to me means: _____

_____

_____

1	I would like my treatment to be aimed at keeping me alive as long as possible. I wish to receive all treatments that the healthcare 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.
2	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:_____
3	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.
4	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
5	None of these represents my wishes. What I want is recorded in my Advance Directive.

Choose only ONE of these five options. **I choose Option Number:** ☐

Surname: ..... NHI: .....

First Names:.....

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

Phone:…….. Mobile:……

MY ADVANCE DIRECTIVE

If you have treatment and care preferences for specific circumstances or you want an advance directive please write the details below. If you can't speak for yourself, it is the responsibility of your healthcare team to apply your advance care plan and any advance directive. When applying the advance directive, they must be confident that you: (1) fully understood what you were asking for; (2) were free from influence or duress from someone else, and (3) meant this to apply to the current situation.

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 recognise anyone	*Example: allowing a natural death*	*Example: comfort measures*	*Example: Artificial feeding*

☐ **If I have left this section blank, I am happy with the choice I made on the previous page and have no other preferences.**

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 healthcare providers caring for me.

Name:_____

Address:_____

PHONE:_____ Signature: _____ Date: _____

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: _____

PHONE:_____ Signature: _____ Date: _____

Surname: ..... NHI: .....
First Names:.....
Date of Birth: ..... /..... /..... Sex: .....
Phone:…….. Mobile:……

7. AFTER MY DEATH

My wishes for organ and tissue donation:

My wishes for caring for my body immediately after death:

After I die I would like to be: ☐ Buried ☐ Cremated

For my funeral or tangi I would like:

I would like my last resting place to be:

This is important to me because:

Things I would like my loved ones to know:

My will and other important things can be found:

Document/item	**Where it is**	**Notes**
My Will		
My Enduring Power of Attorney documents		

Source: Adapted from My Advance Care Plan & Guide (ACP Cooperative 2016) for purposes of electronic scanning & storage of ACP. Review date: May 2018