DecisionAssist
Palliative Care and Advance Care Planning for Aged Care

Advance Care Plan (Aged Care) New South Wales

This *Advance Care Plan* applies to:

....

(title) *(first name)* *(last name)*

Address; ....

Has an Enduring Guardian (regarding health care decisions) been appointed? ☐ **Yes** ☐ **No**

Enduring Guardian/s

Name/s : ....

Contact Number(s): ....

....

Alternate Enduring Guardian

Name: ....

Contact Number(s): ....

....

COPY OF ENDURING GUARDIAN DOCUMENT (IF NOMINATED) ATTACHED? ☐ **Yes** ☐ **No**

If you are unable to answer the following questions for yourself, then it is assumed your Enduring Guardian or trusted representative will answer on your behalf.

Current state of health:

In your own words – please explain your /the client's current health problems:

....

....

....

Values and beliefs:

What are the things that matter to you/the client the most? (Eg: family and friends, familiar activities, independence, spiritual beliefs, religious practices, cultural beliefs).

....

....

Future health situations:

What health conditions would you/the client find unacceptable?: (Eg: can't talk, can't walk, can't eat /drink normally).

....

....

....

Specific treatments:

Please write any specific treatments that you/the client would or would not want:

Wanted: ....

....

....

Not wanted: ....

....

....

Goals for end-of-life care:

What do you hope for most when you are near the end of your life? (E.g: presence of family or other persons; access to places or items of significance; music; any personal, religious or cultural practices to be followed):

....

....

....

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Advance Care Plan (Aged Care) New South Wales (cont.)

My/the client's requests: (*Initial ONE box which best describes your/the client's wishes***)**

☐ If I am acutely ill, and it is reasonably certain that I will not recover, I want to be allowed to die naturally in my familiar surroundings. I do not want my life prolonged by extraordinary or overly burdensome treatments. I wish to receive palliative care that includes treatments to keep me comfortable, pain relief, and be offered food and drink of my choice.

OR

☐ In the event of sudden or significant deterioration in my health I request to be transferred to hospital for assessment and possible treatment

For example: ....

OR

☐ I would like all decisions about medical treatments to be made by my doctors and those I have listed below. I request that they consider my wishes as outlined in this Advance Care Plan.

Declaration by competent# person:

I ask that if possible my Enduring Guardian or trusted representative(s) include the following people in discussions and decisions about my health care:

....

....

....

I, *(Print name)* ....

....

declare that the information completed above is a true record of my wishes on this date.

Signature: ....

Date: ....

Witness Name: ....

Witness Signature: ....

Relationship: ....

Date: ....

#For definition regarding competence please refer to the ACP Information Page

OR

Declaration by Enduring Guardian / Trusted representative (on behalf of a non-competent person):

I, *(Print name)* ....
declare that the information completed above is a true record of what I understand to be the client's wishes on this date.

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

Relationship: ....

Address: ....

Witness name: .... Witness signature ....

Doctor's review of plan: Date: ....

Name: ....

Signature: ....

Staff Member completing form: Date: ....

Name: ....

Signature: ....