Canterbury
District Health Board
Te Poari Hauora ō Waitaha

SURNAME .....NHI: .....
FIRST NAME: .....DOB: .....
ADDRESS:.....
.....POST CODE.....:
(Affix patient label)

Child Health End of Life Care Plan

Primary Consultant: _____

Ward: _____ **Date of Admission:** _____

A discussion about end of life care and allowing a natural death in relation to

_____ (name of child) whose diagnosis is

_____

was held on _____ (date). The following people were involved in the discussion:

_____

_____

_____

_____

_____

Allowing a natural death (AND) and providing palliative care does not indicate a withdrawal of care; but the provision of symptom management; psychosocial and spiritual support and comfort during the end of life period.

The following goals of care were identified:

Symptom management:

_____

_____

_____

_____

_____

_____

Treatment:

_____

_____

_____

_____

_____

_____

Psychological / Social / Spiritual support:

_____

_____

_____

_____

_____

_____

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Child Health End of Life Care Plan

Acute Deterioration Measures
In the event of an acute deterioration, the care to be provided may include, as appropriate:

Response	Yes	Withhold
Call to arrest team		
Nasopharyngeal suctioning		
Oxygen - passive		
Oxygen - bag & mask		
Continuous positive airway pressure (CPAP)		
Intubation		
Cardiac compression		
Defibrillation & arrest medications		
Antibiotics (stipulate oral/IV)		
ICU / HDU admission (specify)		
Other (Specify)		

Is a referral to the Palliative Care Team needed for symptom management and or psychological / social or spiritual support of the child and family?	☐ Yes	☐ No
If yes, has the referral been made?	☐ Yes	☐ No

Have the parents/guardian agreed to the acute deterioration measures (above) being an enduring plan? If no, the parents/guardian have agreed that this care plan and the acute deterioration measures will be reviewed in **(timeframe)**_____ Parents/guardian signature **(Optional)**: Print Name:_____ Signature/s: _____ Date: _____	☐ Yes	☐ No

This reflects the care options discussed and agreed. It is understood that these decisions can change after discussion at any time.

Senior Medical Officer completing this form

Print Name:_____ Designation: _____

Signature:_____ Date: _____

Contact Number: _____

Date of Review	Order remains the same? If no, complete a new form	Signature of Medical Officer completing review	Print Name and Contact Number
	Yes / No		
	Yes / No		
	Yes / No		
	Yes / No		

☐ **Copy of EOL plan sent to GP**
☐ **Copy of EOL plan given to family**
☐ **Copy to Blue Card folder (CAAU)**
☐ **Copy to St John Ambulance Service (Fax 3537112)**