our voice | Advance Care Planning
to tātou reo

Surname: _____
First Name/s: _____
NHI Number: _____ DOB: __ / __ / __
Address: _____
_____
Phone: _____ Mobile: _____

MY ADVANCE CARE PLAN

If you have had a chance to think about the care you want towards the end of your life, you may want to write your thoughts down.

Use this plan to write down what you want health professionals, friends and family/ whānau to know if you could no longer tell them yourself.

There is a section on medical treatments which is important to discuss with your doctor if possible, before you complete it.

This plan is for you and about you. Complete as much as you want. You can show it to anyone involved in your healthcare.

You can add to it as often as you like and change your decisions at any time.

Please take it to your doctors or nurses to discuss it and then you can both have copies. It can be forwarded through your doctor to others who may need it, with your consent.

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_____
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MY ADVANCE CARE PLAN

Please use this plan to inform my care only if I am unable to inform you directly.

My Enduring Power of Attorney (for personal care and welfare)

First name(s): ..... Last name: ..... Relationship: .....

Address: .....

Home Phone: ..... Daytime Phone: ..... Mobile Phone: .....

Please try to include the following people in decisions about my care:

First name: ..... Last name: ..... Relationship: ..... Phone: .....

First name: ..... Last name: ..... Relationship: ..... Phone: .....

First name: ..... Last name: ..... Relationship: ..... Phone: .....

First name: ..... Last name: ..... Relationship: ..... Phone: .....

I have made a Will (tick): Yes ☐ No ☐ It is held by: .....

If I can no longer tell you myself I want those who care for me to know:

The following is important to me:
(this can include your hopes and fears, practical matters (eg you like the TV on, you like to be outside), family concerns, spiritual care you would like, anything else you can think of)

.....
.....
.....
.....

This is what makes life meaningful to me (this may include values, people, pets, ways you would like those caring for you to look after your spiritual and emotional needs, and anything else you want);

.....
.....
.....
.....

I would like my family and friends to know and remember these things:

.....
.....
.....
.....

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_____
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MY ADVANCE CARE PLAN

Please use this plan to inform my care only if I am unable to inform you directly.

When I am dying the following are important to me (tick):

- ☐ Keep me comfortable
- ☐ Take out tubes and lines that are not adding to my comfort
- ☐ Let my family and friends be with me
- ☐ Offer me something to eat and drink
- ☐ Stop medications that do not add to my comfort
- ☐ Attend to my spiritual needs
- ☐ Other.....

.....

The place I die is important to me (tick): ☐ Yes ☐ No

When I am dying I would like to be cared for (tick):

- ☐ At home, which for me is: .....
- ☐ In Hospice
- ☐ In hospital
- ☐ Other:.....

.....

Please care for my body by ensuring the following:

I would like to be (tick): ☐ Buried ☐ Cremated

I would like the following as my end of life ceremony or funeral:

.....

.....

.....

.....

I would like to donate my organs and/or tissues for transplantation. (tick): ☐ Yes ☐ No

Other comments:.....

.....

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_____
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MY ADVANCE CARE PLAN

Please use this plan to inform my care only if I am unable to inform you directly.

Specific Treatment and Care Preferences (please fill out with the help of your Doctor or Nurse)
These expressed preferences should be used to guide clinical decisions in the circumstances that I have set out below:

I would / would not want:	In these circumstances:

For Signature

1. I understand this is a record of my preferences to guide my healthcare team in providing appropriate care for me.
2. I understand that it will only be used when I am unable to make decisions for myself.
3. I understand that medically futile and/or inappropriate treatments will not be administered even if this is my expressed preference.
4. I acknowledge that this record may be held in an electronic form and will be made available to other health care providers for purposes of treating me.

Signed: ..... Date: .....

Witness (Health Professional):

Signed: ..... Date: .....

First Name(s): ..... Last Name: ..... Designation: .....