

Surname: First Name/s:	
NHI Number:	DOB://
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.

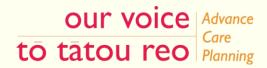
There is a section on medical treatments which is important to discuss with your doctor if possible, before you complete it.

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.



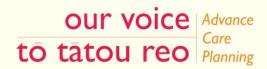


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Please use this plan to inform my care only if I am unable to inform you directly.

. ,	irst name(s):Last name:Last name:			
	Daytime Phone:			
Please try to include	the following people in o	decisions about my care	:	
irst name:	Last name:	Relationship:	Phone:	
irst name:	Last name:	Relationship:	Phone:	
irst name:	Last name:	Relationship:	<mark>Phone:</mark>	
irst name:	Last name:	Relationship:	Phone:	
have made a Will (tic	k): Yes 🗆 No 🗆	lt is held by:		
If I can no longer te	ll you myself I want tho	se who care for me to	know:	
	rtant to me: hopes and fears, practical n rns, spiritual care you woul			
	e meaningful to me (this ma o look after your spiritual a			

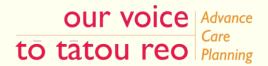


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When	I am dying the following are important to me (tick):		
	Keep me comfortable		
	Take out tubes and lines that are not adding to my comfort		
	Let my family and friends be with me Offer me something to eat and drink		
	Stop medications that do not add to my comfort		
	Attend to my spiritual needs		
	Other		
	I am dying I would like to be cared for (tick): At home, which for me is: In Hospice In hospital Other:		
I would	care for my body by ensuring the following: d like to be (tick): Buried Cremated d like the following as my end of life ceremony or funeral:		
l would	d like to donate my organs and/or tissues for transplantation. (tick): Yes No comments:		



I would / would not want:

Surname:	
First Name/s:	
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In these circumstances:

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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:

Fo	or 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		



Signed: _____ Date: ____

providers for purposes of treating me.

Witness (Health Professional):