ACT Government | ACT Health

Advance care planning Document

Statement of Choices

competent adults

Surname:

Address

Given name

Preferred name

Date of birth DOB

URN:(hospital use)

This symbol means there is information available to help you complete the document.
Please refer to the Frequently Asked Questions and Tips for Completion.

Other advance care planning documents completed:

Enduring Power of Attorney (EPOA) - legally appointed Substitute Decision Maker (SDM)

I have an Enduring Power of Attorney - completed on:

Attached? ☐ Yes ☐ No

My legally appointed Substitute Decision Maker/s also known as Attorney/s are:

Name	Contact	Relationship:
Name	Contact	Relationship:
Name	Contact	Relationship:
Name	Contact	Relationship:

A Health Direction

☐ I have completed a Health Direction with my GP/Doctor on _____ and it is attached.

☐ I have not completed a Health Direction.

☐ I know that I can add a Health Direction or change a Health Direction at any time in the future.

Donor Registration

☐ I am a registered donor.

For more information about organ and tissue donation www.donatelife.gov.au or contact Donate Life on 5124 5625

Copies of my documents have been given to:

☐ My Substitute Decision Maker/s (Attorney/s)

☐ Family members/friends / chosen family

☐ My GP / Specialists

☐ _____

☐ _____

☐ My Health Record

☐ The Canberra Hospital

☐ Calvary Public Hospital

☐ _____

☐ _____

My main message for my healthcare providers is:

(***optional:*** use this section if there is something you want your healthcare providers to see immediately, e.g., do not transfer me to the hospital without contacting my son, or do not attempt CPR)

A. My values and wishes - What matters most.

These are my values and wishes that I want considered if my chosen decision makers are required to make health care decisions for me. They know how I want to live, and how I would like to be treated. This Statement of Choices is my voice. Please respect and consider my wishes.

I ask all family members and healthcare professionals involved in my care to do the same.

My desired quality of life and acceptable recovery after illness or injury (living well):

(e.g., Think about your past experiences, best hopes, worst fears. What matters to you, how you would like to live, what you value, enjoy and what gives your life meaning and quality; what circumstances might be unacceptable).

My understanding of my current health conditions:

(e.g., include any chronic or life limiting illness or health concerns. You can add personal and medical matters that you need to be managed or considered, i.e., medications required, hearing impairment, or assistance and care needs).

More important information:

(e.g., include the following people in my health care decisions if there is time. Any religious, spiritual, or cultural needs that are important to you. A message, or things you want your family to know).

B. My choices for CPR and other life prolonging and medical treatments

These are my choices if you ever need to decide to accept or refuse care for me.

I understand that in an emergency, difficult decisions may need to be made quickly and my substitute decision makers may not be available or able to be consulted. Please follow my wishes where possible.

My choices for cardiopulmonary resuscitation (CPR):

Initial appropriate boxes/add information

- ☐ I would not like CPR at all. Please allow a natural well supported end of life.
- ☐ I do want CPR if the doctors expect that I will recover to my previously described and desired quality of life (see section A of this document) and it is medically appropriate.
- ☐ I have no preference and am undecided.

Circumstances in which I would not want CPR include:

My reasons for this are(optional):

My choices for other life prolonging and medical treatments:

Initial appropriate boxes/add specific information if necessary, such as treatments wanted, not wanted.

- ☐ I would like all appropriate treatments to keep me alive as long as possible.
- ☐ I would like treatments only if the doctors expect that I will recover to my previously described and desired quality of life (see section A of this document) and it is medically appropriate.
- ☐ I would only like treatments that provide comfort, symptom management, pain relief and dignity.
- ☐ I have no preference and am undecided.

Circumstances in which I would not want life prolonging treatments or specific treatments wanted/not wanted are:

My reasons for this are(optional):

My choices if I am nearing the end of my life:

(e.g., consider what would give you a comfortable end of life and peaceful death, such as preferred place of care, care of pets or spiritual or cultural needs).

My declaration of understanding and witnessed signature.

I, (your full name) _____

of (your address) _____ am of sound mind and:

- I understand the importance and purpose of this Statement of Choices.
- I know this Statement of Choices will ONLY be used to guide future medical decisions when/if I lose the ability to make or communicate my medical treatment choices myself.
- I understand that it is very important for me to discuss and share my wishes with my family, appointed substitute decision maker/s (attorney/s) and health care providers.
- I ask that the choices and guidance provided in this document and discussed with my substitute decision maker/s, attorney/s be respected and followed.
- Regardless of all decisions about cardiopulmonary resuscitation and life prolonging treatments I know doctors will always try to speak with my chosen substitute decision maker/s attorney/s at the time a decision is needed. I understand I will receive all care to relieve pain and suffering.
- I may complete all or part of this document and know that I can change my mind regarding these choices at any time. I can add additional pages if necessary.
- I give permission for this document to be shared with my health care providers.

Cross out any of the above if not applicable

I declare that the information completed in this Statement of Choices is a true record of my wishes on this date:

Signature: _____ Date: _____

Witness Name: _____ Signature: _____

☐ An interpreter assisted with the completion of this form

Review of my Statement of Choices.

This document remains in place until it is updated or withdrawn. Your wishes, condition and treatment options may change over time. It is a good idea to review this plan every few years or if your circumstances change. Sign below if there are no changes to your choices. If your choices change, you will need to complete a new document and provide a copy to the people and places you have nominated on page 1.

Review 1: I have reviewed this ACP, and there is nothing I would like to change.

Signature:	Witness Name:	Signature:	Date:

Review 2: I have reviewed this ACP, and there is nothing I would like to change.

Signature:	Witness Name:	Signature:	Date:

You can submit your completed Statement of Choices and other Advance care planning documents to:

The Canberra Hospital
Health Information Services
PO Box 11 Woden ACT 2606
Email: CHS.HIS@act.gov.au

The Calvary Public Hospital
Health Information Services
PO Box 254 Jamison Centre ACT 2614
Email: HIS@calvary-act.com.au

My Health Record
Add an advance care plan
My Health Record

If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81. If English is not your first language and you need the Translating and Interpreting Service (TIS), please call 13 14 50. For further accessibility information, visit:

www.health.act.gov.au/accessibility
www.health.act.gov.au | Phone: 132281

This form has been adapted from Queensland Government (Queensland Health) Statement of Choices