* 1 5 3 0 6 *

Affix patient label or complete details

Name: _____

Address: _____

_____

DOB: _____ Telephone: _____

URN: _____

ACT Health

Advance Care Plan

Incompetent Person

Attorney under EPA/Guardian *(please circle to identify which role)*

Name: _____

Telephone number(s): _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Date: _____

Alternate Attorney under EPA: *(please circle)*

Name: _____

Telephone number(s): _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Date: _____

The Advance Care Plan includes the following documents:

Enduring Power of Attorney: ☐ Yes ☐ No

Statement of Choices: ☐ Yes ☐ No

Health Direction under Medical Treatment Act 2006: ☐ Yes ☐ No

Copies of the Advance Care Plan have been given to: *(complete as many lines as applicable)*

1. _____ 8. _____
2. _____ 9. _____
3. _____ 10. _____
4. _____ 11. _____
5. _____ 12. _____
6. _____ 13. _____
7. _____ 14. _____

15306(1007)

Advance Care Plan (Incompetent Person)

ACT Health

Statement of Choices

For people who do not have legal capacity to make medical decisions

This document relates to the following person: _____

I understand that he/she has been assessed as not having legal capacity to complete an Enduring Power of Attorney or make medical decisions independently.

I have made choices based on the best interests of the person taking into account their wishes, the wishes of family members and significant others, and the benefits and burdens of treatment. I request that the stated choices recorded below are respected by health professionals now, and in the future.

Please note: The law requires that this statement be taken into account when determining treatment for this person.

1. Stopping or withdrawing Life Prolonging Treatments

Initial the boxes you want and cross out the boxes you don't want. You may write specific requests on the lines provided.

☐ **1.** I would like life-prolonging treatments to be commenced and continued, including Cardio Pulmonary Resuscitation (CPR), while they are medically appropriate and remain in his/her best interests.

You may write specific requests here: _____

_____

Or

☐ **2.** If he/she is acutely ill, unable to communicate responsively with family and friends, and it is reasonably certain that he/she will not recover, I want him/her to be allowed to die naturally and be cared for with dignity. I do not want him/her be kept alive by extraordinary or overly burdensome treatments that might be used to prolong his/her life (e.g. Cardio Pulmonary Resuscitation [CPR]). If any of these treatments have been started, I request that they be discontinued. However, I do want Palliative Care that includes medications, and other treatments to alleviate suffering and keep him/her comfortable, and to be offered something to eat and drink.

You may write here specific treatment(s) that you want or don't want here: _____

_____

_____

_____

2. Other requests with regard to medical care

e.g. Such as circumstances in which he/she does or does not want a particular treatment.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Affix patient label or complete details

Name: _____

Address: _____

_____

DOB: _____ Telephone: _____

URN: _____

ACT Health
Statement of Choices

For people who do not have legal capacity to make medical decisions

3. Other points that are important to me

If the person had other end of life wishes, e.g. organ or body donation, you may wish to attach any documentation to this plan. NB. it is the next-of-kin/family that consent to organ donation.

I ask that doctors include the following persons in my health care decisions if there is time:

_____

_____

_____

_____

_____

If the person is nearing death, I want the following (list things that would be important to them):

_____

_____

_____

_____

_____

_____

Signed by: _____ Date: _____

(Please circle your relationship with the subject)

Attorney/Guardian

Other persons present at discussion and formulation of this plan:

Name	**Relationship**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Doctor's Review of the plan **Date:** _____

Doctor's name: _____

Doctor's signature: _____

ADVANCE CARE PLAN FOR PEOPLE WHO DO NOT HAVE LEGAL CAPACITY[1] TO MAKE MEDICAL DECISIONS
Information Sheet

The Respecting Patient Choices Program is promoting advance care planning in the Australian Capital Territory. This program is about the promotion of autonomy and dignity and not about euthanasia or suicide.

The person to whom this form applies has been assessed as not having the legal capacity to make their own decisions about their future medical care. If, while competent, they have completed an Enduring Power of Attorney appointing an attorney for health care matters their attorney can, while the person remains incompetent, consent to or refuse medical treatment on their behalf (see item 1 below). In the Australian Capital Territory next-of-kin cannot consent to or refuse treatment. Only the nominated attorney/s under the person's Enduring Power of Attorney are able to consent to or refuse treatment on their behalf.

Advance care planning helps families, significant others and healthcare staff to discuss and plan future medical care for the person. This considers the person's current health and future options and their beliefs, values and goals in life. It is important to include the person in these discussions to the best of their ability. Your Respecting Patient Choices Consultant is available to assist and guide you through the process.

If the attorney's under the person's Enduring Power of Attorney are making decisions for this person, the decision-making process - must:

- Take into account what is in the person's best interests
- Take into account the person's previously and currently expressed wishes and values; and
- Involve discussion with any family, carers and significant others

You may wish to record this process by completing an Advance Care Plan. This form will assist you to record the choices you make and a Respecting Patient Choices Consultant will guide you through this process.

Before completing this Advance Care Plan for the person, take time to read the following information carefully. It is important that the person's values and beliefs are considered and reflected within this Advance Care Plan.

1. **If the person has previously completed an Enduring Power of Attorney** their nominated attorney for health care matters will now become the primary decision-maker for the person's medical treatment. Please provide a copy of the Enduring Power of Attorney document to the Respecting Patient Choices Consultant who is assisting you. This will become a part of this Advance Care Plan**.**

Take time to reflect on previous conversations with and values of the person to plan their future care in a way that they would have wanted if they were able to make medical decisions for themselves.

2. **If the person has NOT completed an Enduring Power of Attorney,** or a Guardian has not been previously appointed, then an application for a Guardian to be appointed needs to be made to the Guardianship and Management of Property Tribunal.

3. **Advance Care Planning**

The process of advance care planning requires you to:

- **Understand** the person's current health condition and what medical decisions may need to be made in the future. If you are unclear about this, you should arrange to meet with the person's doctors who can ensure you understand this and answer all of your questions

[1] ***Lack of Legal capacity or competence means the person (a) is incapable of understanding the general nature and effect of the proposed procedure or treatment; or (b) is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the proposed procedure or treatment.***

- **Reflect** on the person's values, beliefs and goals in life both now and before their illness progressed to its current state. It is important to plan the person's future care in a way that you feel they would have wanted if they were able to make decisions for themselves

- **Discuss** the person's medical condition and their values, beliefs and goals with each other and finally,

- **Formulate a plan**. This plan can be documented on the attached 'Statement of Choices for people who do not have legal capacity to make medical decisions'

The Statement of Choices (for People Who Do Not Have Legal Capacity to Make Medical Decisions)

You may wish to record the outcomes of your advance care planning discussions for the person regarding choices about their future medical treatment on the 'Statement of Choices for People Who Do Not Have Legal Capacity to Make Medical Decisions' form. It documents the choices you have made on behalf of the person, based on your knowledge of their wishes and discussions with other family members, carers and significant others. It is not legally binding, but is designed to inform the doctors of your wishes for the medical treatment of the person.

After completing the Statement of Choices the original remains with the person completing it and copies can be given to or discussed with:

- The other attorneys, if applicable
- The person's local doctor (GP)
- The person's family, carer or significant other
- The organisation where the documents have been completed for inclusion in the medical records
- Other hospitals/clinics normally attended by the person (with a covering explanatory letter)

You may wish to give extra copies to others (eg. Spiritual Advisor). If an Enduring Power of Attorney exists, a copy should be attached to the Statement of Choices.

What if a person regains their legal capacity?

A person who regains their legal capacity is responsible for their medical decision-making. The attorney/s power ceases.

Ending an Enduring Power of Attorney

An Enduring Power of Attorney can be changed or revoked –

- By the person if they regain their legal capacity;
- By Guardianship and Management of Property Tribunal if it determines that it is not being used in the person's best interests;
- By the resignation of the attorney/s. They should inform the family members, significant others and the health care providers.

How can you change or revoke the Statement of Choices?

The person who completes the Statement of Choices can change or revoke the document by completing a new document and informing the relevant people.

Need further information?

If you need assistance in completing this document or would like more information please contact a Respecting Patient Choices Consultant:

Name: Number: