ADVANCE CARE PLAN
FOR THE PERSON LACKING CAPACITY

UR NUMBER.....

SURNAME.....

GIVEN NAMES.....

DATE OF BIRTH .....
Please fill in if no Patient Label available

This Advance Care Plan applies to the care of ..... *(print name)*

I am the 'person responsible' according to the Guardianship and Administration Act 1986 (Victoria) and am authorised to make health care decisions for the above named person, including consent to medical treatment or withholding of consent. I understand that the person has permanently lost the capacity to make their own healthcare decisions and all decisions I make on their behalf must be made in their best interests, taking into account their wishes as far as these can be ascertained.

1. Substitute Decision-Maker for Medical Treatment

This form is being completed by: (tick the applicable box)

- ☐ Medical Enduring Power of Attorney
- ☐ Enduring Guardian
- ☐ Spouse or Partner in a close and continuing relationship
- ☐ Primary Carer who has been providing care on a non-professional basis (if in residential care includes the person acting as their carer in the immediate period prior to admission)
- ☐ Nearest relative
- ☐ Other (please specify): .....

Name and contact details of the person responsible for completing this Advance Care Plan

Name	
Contact Details	
Date Completed	

2. Values and Beliefs

What does the person most value in life? For example: What interests or activities do they enjoy? What mental or physical functions are most important for them to have a reasonable quality of life? What personal, cultural, spiritual or religious values are important to them?

3. State of Health

What are the person's health problems or medical conditions? How do these affect their life?

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4. Goals for Care

Taking into **consideration the person's values, beliefs and health**, how much medical intervention do you believe is right for them or they would prefer if their health seriously deteriorates?

Sign your initials in the box that best describes the preferred level of treatment for the person

Comfort Care - Palliative Treatment

Promote comfort, dignity and quality of life

- Order tests only for the purpose of managing symptoms effectively
- Provide treatments to achieve good pain relief and to ease any distressing symptoms
- Do surgical procedures only if considered the most effective measure to relieve pain or improve comfort
- Provide therapies that contribute to physical, spiritual, mental and emotional comfort

Restorative Care - Limited Treatment

Restore wellness and physical function by treating all reversible conditions

- Provide essential tests, treatments and therapies to aid recovery from illness and reverse declining function where this is possible. Admit to hospital if necessary for investigations or treatment.
- Provide surgery to treat painful or reversible conditions where risks do not outweigh potential benefits
- Avoid burdensome treatments, intensive care and life support machines

Curative Care - Active Treatment

Aggressively treat all life threatening conditions to gain a possible cure

- Provide all standard medical and surgical treatments to cure the condition where this is possible
- Admit to intensive care for close monitoring, a short trial of treatment, or to aid recovery from surgery using mechanical ventilation (breathing machine)
- Avoid high risk surgery with a significant risk of death or very serious complications

Life Prolonging Care - Intensive Treatment

Do everything medically possible to prolong life

- Use all available life support including mechanical ventilation (breathing machine); drug infusions to maintain blood pressure; procedures or devices to maintain heart rhythm and function; renal dialysis (kidney machine); tubes to drain lungs, stomach, bowel or bladder.
- Remain in a hospital intensive care unit for extended periods (weeks to months)
- Do high risk surgery, even if there is a significant risk of death or very serious complications

Other considerations or points to include or exclude in the person's care:

UR NUMBER.....

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5. Limitation of Treatment

Are there any situations where you believe the person would rather have treatment to keep them comfortable than to prolong their life or delay their death from natural causes?

☐ No

☐ Yes - describe below

6. Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary Resuscitation may not be available or considered medically suitable depending on the person's pre-existing level of health and medical condition. If first attempts to revive the person are successful, further life support treatments and hospitalisation will be necessary.

Sign your initials in the box to indicate your belief as to the person's preference for CPR, or where this is unknown, what you would agree to on their behalf:

If the heart stops beating or there are no signs of life **commence** Cardiopulmonary Resuscitation in an attempt to restart the person's heart

If the heart stops beating or there are no signs of life **do NOT commence** Cardiopulmonary Resuscitation in an attempt to restart the person's heart

Special considerations that apply to cardiopulmonary resuscitation:

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7. Tube Feeding

If the person is permanently unable to safely swallow enough food and fluids to sustain their life would they want liquid food given through a tube surgically inserted directly into their stomach (PEG tube) or if the person's preference is unknown would you consent to this treatment on their behalf?

☐ No

☐ Yes

Special considerations that apply to tube feeding:

8. Refusal of Specific Treatment

Are there any **specific medical or surgical treatments** that you know **the person would not want** or you would **NOT** consent to in the future on the person's behalf, even if these might save or prolong their life?

☐ No

☐ Yes (if you are the person's Medical Enduring Power of Attorney consider completing a legally binding *Refusal of Treatment Certificate* with the person's doctor)

Specific treatments that I would not consent to on the person's behalf under all circumstances are:

9. Preferred Location of Care

If the person is nearing the end of life and their **health seriously deteriorates** what would be the person's preferred place of care? **Sign your initials** in the box you believe describes the best option for them.

If circumstances allow and time permits the preference is for the person:

	To transfer to a hospital
	To be cared for at home or in their usual residential care facility. Avoid transfer to hospital unless it is not possible for their usual carers, doctor and community based support services such as home hospice nurses to provide the necessary care.
	To be cared for in a hospice or palliative care unit

Special considerations that apply to preferred location of care:

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10. End of Life Care

If the person is dying what kinds of things would be important or bring them the most comfort?
Examples: physical touch; favourite music; favourite food or drink; family presence; special items of significance; cultural rituals or customs; religious, spiritual or pastoral care, clergy visits, prayer.

If death is near the person would like the following:

11. Organ Donation

Are you aware of any views the person may have on organ and tissue donation?

Would the person want to donate body organs and tissues if circumstances allow or if their views are not known would you agree to this on their behalf? Yes ☐ No ☐

Has the person registered to donate their body to science after death? Yes ☐ No ☐

Comments:

12. Additional information

Is there any further information that you would like known regarding future health care preferences for the person or other messages you would like to write here for the healthcare team?

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Declaration of the Person Responsible

I declare that I have taken into account the person's known values and wishes to the best of my knowledge and ability. I have expressed care preferences on their behalf that I believe are in their best interests.

Signature: ..... Date: ...../...../.....

Print Name: .....

Print Address:

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Doctor's Declaration

I consider that ..... (*name of person*)
does not have capacity to make decisions about their medical care and I confirm that it is necessary for the 'person responsible' to act on their behalf. This Advance Care Plan should be taken into account when considering any medical treatment plan for the person and the 'person responsible' consulted when considering specific medical treatment.

Signature: ..... Date: ...../...../.....

Print Name: .....

Medical Practice or Hospital Address:

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It is recommended that you **review** this Advance Care Plan regularly, especially if there is an important change in the person's medical or personal circumstances. It will be necessary to rewrite the form if significant changes need to be made.

Date of Review	Your Signature (Person Responsible)