

Name:	NHS no:
Address:	Date of birth:
Postcode:	Hospital no:
GP and practice:	

This form is to record the advance care wishes of a person with mental capacity. The decisions recorded here are not legally binding, but should inform any clinical decisions made on behalf of the person.

Date:

1 INVOLVING OTHERS IN DECISION MAKING

Have you appointed a **Lasting Power of Attorney**?

Name(s): Tel no(s):

If not, is there **someone you would like to be consulted** if the doctors ever have to make treatment decisions on your behalf?

Name(s): Tel no(s):

2 DEPENDENTS

Do you have anyone **dependent** on you for their care (e.g. children, partner or elderly relatives)?
Record who, what relationship, and age:

If so, have you made any plans for their care if you are unable to look after them?
Record brief details:

3 TREATMENT & CARE PREFERENCES / PLACE OF CARE

Have you ever made a "Living Will" - either an **Advance Decision to Refuse Treatment (ADRT)** or a **written statement of your wishes** about medical treatment?

If so, what does it say and where is it kept? (Is a copy available in the medical records?)

If not already covered by the above -
Do you have a **preference about where you would like to be cared for** if you become less well, including when you are nearing the end of your life?

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3 TREATMENT & CARE PREFERENCES (contd.)

Some people wish to set a limit, or ceiling, to their treatment. Are there any **treatments or interventions** you would **not** want in some circumstances? (⇒ optionally use next page)

Is there anything you are worrying may happen in the future? (e.g. difficulty breathing, being left alone)?

4 CARE AROUND LAST DAYS OF LIFE - PREFERENCES OR WISHES / PLACE OF DEATH

This section contains some questions about your **care around the last days of your life**:

Do you wish to express a **preference about where you would like to be cared for** when you are dying?

Do you have any **religious or spiritual needs** for care around the time of death?

Have you **made a will**?

Would you like your organs or tissues to be considered for **donation**?

Have you considered your "digital legacy" e.g. on-line content on Facebook

(Further information on this is available at: www.deadsocial.org)

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OPTIONAL: Use this page to record more details of patient preferences about specific medical treatments or interventions.

* Consider adding possible treatments specific to the patient’s condition e.g. dialysis for advanced kidney disease

*** If the patient has a clear understanding of his/her preferences, and wishes to refuse treatments under specific conditions, you should advise that completing an Advance Decision to Refuse Treatment (ADRT) could make such decisions legally-binding.**

“Some people wish to set a limit, or ceiling, to the care they receive.

If the following treatments were medically appropriate, how would you feel about these interventions?”

Treatments	Would want	May want it if it were primarily to maintain dignity or comfort	Not under any circumstances	Comments
Antibiotics for a serious (life-threatening) infection				
Intravenous hydration (a ‘drip’)				
Admission to hospital				
Admission to an Intensive Care Unit				
A mechanical ventilator (to help with breathing)				
An endo-tracheal tube used in order to perform the above				
Nasogastric, gastrostomy, or other enteral feeding tubes introduced to feed				
Attempted Cardio-pulmonary resuscitation (CPR)			(Complete a DNA-CPR form)	
Other...				

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Emergency situations

“Although life-threatening emergencies are very uncommon, you may wish to consider how you would like others to respond if a sudden life-threatening event should occur at home, for example a large haemorrhage/bleed. Which would be your priorities?”

	Comments
To get to hospital a.s.a.p. to receive active treatment i.e. a 999 emergency ambulance.	
To control pain or other symptoms as quickly and effectively as possible, wherever that may be.	
To stay at home if at all possible.	
To put the wishes or needs of partner/carer first.	
Other priority...	

ADDITIONAL INFORMATION

*Would you like to record **any other preferences or choices** about your healthcare?*

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If appropriate, has a DNA-CPR form been completed?

Does the person consent to share this information with other healthcare professionals?

Does the person consent to record this information in their computerised healthcare record?

Has the person discussed this information with their next-of-kin/family?

Permission to discuss this information with next-of-kin/family if appropriate?

Please record (by ticking) all who have been informed:

- GP
- District Nurses
- Out-of-Hours primary care service
- Hospital team(s)
- Specialist Palliative Care Team
- Ambulance Service (WAST)
- Others:

Where is this document kept?
e.g. where in the house

If the information on this form needs to be updated or changed, please strike through all pages of this form, and ensure that you inform all those listed above.

Signature of patient (optional)	Print Full Name & Contact Information	Date
Signature of care professional helping with form	Name & Contact	Date
GMC/NMC Number:		