SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

"MY WISHES" ADVANCE CARE PLANNING PROGRAM

STATEMENT OF VALUES & WISHES

(Completed by the patient)

SURNAME		MRN	
OTHER NAMES		[ ] MALE	[ ] FEMALE
D.O.B. ______/_______/_________	M.O.		
ADDRESS			
LOCATION			

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Instructions to staff

Does the person already have an existing advance care plan or advance care directive of any type or format?

[ ] YES [ ] NO. IF YES, PLEASE INSERT INTO ALLOCATED SPACE IN MEDICAL RECORDS AND CONSIDER IF THIS FORM NEEDS TO BE DONE AS WELL.

Staff should review this *Statement of Values and Wishes* or any other advance care planning documents attached and use them to inform their treatment decisions. How this occurs should be recorded in the patient's medical record.

PROVIDING ANSWERS TO THESE QUESTIONS WILL HAVE TWO BENEFITS. IT WILL HELP YOU TO ENGAGE IN A DISCUSSION WITH YOUR LOVED ONES ABOUT YOUR VALUES AND WISHES, AND IT WILL HELP TO PROVIDE SOME EVIDENCE OF YOUR WISHES IF DIFFICULT DECISIONS NEED TO BE MADE ABOUT YOUR CARE IN CIRCUMSTANCES WHERE YOU CANNOT MAKE THESE DECISIONS FOR YOURSELF.

1. Do you have concerns about the possibility of losing capacity and needing others to make decisions for you? If so, what are these concerns?

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2. Have you seen anyone else's end-of-life experiences that you would either want for yourself or wish to avoid? If so, can you describe these.

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3. Do you have religious or spiritual beliefs that would affect decisions about your care around end-of-life? Are there religious or spiritual needs you would like attended to if you become unwell? If so, can you describe these.

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BINDING MARGIN - NO WRITING

STOCK NO.: xxxxxxxx Nov 09 / Rev 0

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4. In terms of your views about your quality of life in the future, at what point would you want the goals of medical treatment to switch from attempting to prolong life to focusing on palliative care? (People may describe this in terms like their loss of ability to recognise people, feed themselves, walk, talk etc).

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5. If you reach that point in the future where:
   - your quality of life is very low as defined in the previous question;
   - your underlying medical condition is irreversible i.e will not get better;
   - you have a severe life-threatening illness and you are not able to express your wishes at the time and

   a) Your heart suddenly stopped, would you wish to have cardiopulmonary resuscitation (CPR) and life support (including giving your heart an electric shock to restart it or putting a tube into your lungs to support your breathing?) [ ] Yes [ ] No

   b) You could no longer safely take food or fluid by mouth, would you wish to be fed long-term by a tube into your stomach? [ ] Yes [ ] No

Note: *Active resuscitation may be considered medically futile in end stage disease & may not be offered as a treatment option.*

6. Do you have any other special requests, preferences or other comments that would help others if they have to make end-of-life decisions on your behalf?

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7. Have you expressed your wishes regarding organ / tissue donation by registering with the Australian Organ Donor Register? [ ] Yes [ ] No

8. The person or persons I want to consent to medical treatments for me if I reach a point where I am not able to give my own consent is/are: ____________________

[The person completing this form should check if the person(s) they want would be recognised by the health system as the Person Responsible to give consent (as defined under the NSW Guardianship Act) - see attached Information Sheet. If this is NOT the case, the person should obtain information about Enduring Guardianship and consider appointing their preferred decision maker as their Enduring Guardian.]

Name of Patient: ____________________ Sign: ____________________ Date: __________

It is strongly recommended this form be witnessed. It is also strongly recommended that it be discussed with your Doctor and Person Responsible so they are aware of your wishes.

Name of Witness: ____________________ Sign: ____________________ Date: __________

Name of Doctor / Healthworker: ____________________ Sign: ____________________ Date: __________

Dates this form was reviewed to check its currency:

Name of Patient: ____________________ Sign: ____________________ Date: __________

Name of Patient: ____________________ Sign: ____________________ Date: __________

BINDING MARGIN - NO WRITING

STATEMENT OF VALUES AND WISHES

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