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|-----------------------|------|---------------------|
| SURNAME | | MRN |
| OTHER NAMES | | [] MALE [] FEMALE |
| D.O.B. ____/____/____ | M.O. | |
| ADDRESS | | |
| | | |
| LOCATION | | |

“MY WISHES” ADVANCE CARE PLANNING PROGRAM

STATEMENT OF VALUES & WISHES
 (Completed on behalf of the patient by their Person Responsible)

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.

A Doctor needs to either complete the form with the Person Responsible or at least be part of the discussion and verify that the patient does not have capacity to provide their own consent. Guidelines about establishing capacity can be found in the *Capacity Toolkit* (2008) published by NSW Attorney Generals Department.

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 THE FAMILY AND LOVED ONES TO REFLECT ON WHAT THE PERSON'S WISHES WOULD BE, AND IT WILL HELP TO PROVIDE SOME EVIDENCE OF THE PERSON'S WISHES IF DIFFICULT DECISIONS NEED TO BE MADE ABOUT THEIR CARE AT SOME TIME IN THE FUTURE.

It has been established by Dr _____ that _____ does not have capacity to provide consent for any health care treatments she/he may need in the future because they are incapable:

- [] of understanding the nature and effect of treatment required and/or
- [] of communicating whether or not they consent to treatment.

The person completing this form on the patient's behalf is considered their Person Responsible on the basis of being:

- [] Guardian [] Spouse
- [] Unpaid carer [] Friend or relative

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

2. Do you think the person has seen anyone else's end-of-life experiences that they would want to have themselves or would want to avoid? If so, can you describe these.

BINDING MARGIN - NO WRITING

STOCK NO.: xxxxxxxx Nov 09 / Rev 0

STATEMENT OF VALUES AND WISHES - PERSON RESPONSIBLE

AMR001.001

| | |
|--|---------------------|
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3. Does the person have religious or spiritual beliefs that would affect decisions about their care around end-of-life? Are there any religious or spiritual needs that you think they would want attended to if they became unwell? If so, can you describe these.

4. In terms of the person’s own views about their quality of life in the future, at what point do you think they would 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 ability to recognise people, feed themselves, walk, talk etc).

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

6. How were your answers to these questions developed? (e.g. have you discussed these issues with the patient in the past, or with others close to the patient?)

Name of Person Responsible: _____ Sign: _____ Date: _____

Name of Healthworker assisting completion: _____ Sign: _____ Date: _____

Name of Doctor verifying incapacity: _____ Sign: _____ Date: _____

Dates this form was reviewed to check its currency:

Name of Person Responsible: _____ Sign: _____ Date: _____

Name of Person Responsible: _____ Sign: _____ Date: _____

Name of Person Responsible: _____ Sign: _____ Date: _____

BINDING MARGIN - NO WRITING

STATEMENT OF VALUES AND WISHES - PERSON RESPONSIBLE

AMR001.001