STATEMENT OF CHOICES

ADVANCE CARE PLANNING

The time may come when you cannot speak for yourself. By completing this Statement of Choices, you can record your wishes about your future health care.

Queensland Government

Advance Care Planning

If you were suddenly injured or became seriously ill,
who would know your choices about the health care you would want?

What is advance care planning?

Advance care planning means thinking now about what health care you would want in the future and communicating your wishes. Advance care planning gives you the opportunity to discuss your beliefs and values, and helps give you peace of mind that you will receive the right care, at the right time, in the right place.

Why plan ahead?

- To ensure the treatment and care you are offered in the future is in line with your wishes.
- To ensure your loved ones won't have to make difficult decisions on your behalf without knowing what you would have wanted.
- To ensure decisions about your health care are not made in a crisis only.

When does an advance care plan come into effect?

Your advance care plan only comes into effect if you are unable to make or communicate your own health care decisions.

What if my family member or significant other is currently unable to make health decisions and they do not have an advance care plan?

A recognised substitute decision maker can still make a plan for that person. This plan should be based on that person's best interests, their expressed wishes and the views of their significant others. It should take into account the benefits and burdens of the person's illness and medical treatment.

Does an advance care plan apply across all health care environments?

Yes, you can give a copy of your advance care planning documents to all health care services to ensure your wishes are known and considered. This includes public hospitals, community heath centres, your GP and any other health facilities you may access.

Ready to start?

1. **Think** about your future health care preferences and, if needed, who you might want to make decisions on your behalf.
2. **Talk** about your future treatment and care preferences with your family and friends.
3. **Discuss** your condition and treatment options with your doctor.
4. **Decide** your future health care preferences and let your family and friends know.
5. **Record** your wishes using forms in this kit, and/or the other documents listed over the page.
6. **Give** copies of your plan to your family members, your doctor and your hospital.
7. **Review** and update your advance care planning documents regularly.

Queensland Government

Think now. Plan sooner. Peace of mind later.

Advance Care Planning documents used in Queensland

An advance care plan usually consists of one or more of the following documents:

1. Statement of Choices (FORM A or B)

This document focuses on a person's wishes and choices for their health care into the future. It is used to guide management of care if a person is unable to communicate their decisions.

2. Enduring Power of Attorney

(for health/personal matters)

This is a legal document that nominates a family member or friend (more than one can be nominated) to make important health decisions when a person is unable to do so.

3. Advance Health Directive

This is a legal document that records a person's directions about future health care for a time when they may be unable to communicate.

You can obtain a copy of these documents at:
www.my**care**my**choices**.com.au

Completion checklist

After completing the Statement of Choices make sure:

- ☐ All 3 pages have been completed
- ☐ Page 2 has been signed by you
- ☐ Page 3 has been signed by a doctor
- ☐ A copy of the document has been sent to your local Hospital and Health Service (see details below under "Contact information")
- ☐ The substitute decision maker has a copy of the document
- ☐ A copy has been given to your family or friends (optional)
- ☐ The original document is stored in a safe but accessible place

Notes and to-do list:

____
____
____
____
____
____
____
____
____
____

Contact information

Advance Care Planning, CISAS, Sunshine Coast Hospital and Health Service:

PO Box 547,
Nambour QLD 4560

Fax: (07) 5313 4284
Email: SC-ACP@health.qld.gov.au

Sunshine Coast Hospital and Health Service (HHS) is located in south east Queensland and extends through the coastal and hinterland areas from Caloundra in the south to Gympie in the north. Hospitals located in the Sunshine Coast HHS region include Nambour General Hospital, Caloundra Health Service, Gympie Hospital and Maleny Soldiers Memorial Hospital.

GLOSSARY OF TERMS

Advance Health Directive

In Queensland, an Advance Health Directive is an advance care planning document stating a formal set of instructions for your future health care. It is used to inform your doctors of your choices when you become unable to make health care decisions for yourself.

This document allows you to record your wishes relating to specific medical circumstances. It is a legal document that can only be completed by you for your future care if you eventually lose the capacity to communicate for yourself. It must be completed with your doctor and witnessed by a Justice of the Peace, Commissioner for Declarations, a lawyer or notary public.

Capacity

Capacity refers to a person's ability to make a specific decision in a particular area of their life. A person has capacity when they have the ability to understand the information provided by a doctor about their health and treatment options and are able to make a decision regarding their care. The person also needs to be able to communicate their decision in some way and the decision must also be made of the person's own free will.

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation is a combination of techniques that can include chest compressions and electrical shocks. It is designed to maintain blood circulation whilst waiting for treatments to possibly start the heart beating again on its own. The success of CPR depends on a person's overall medical condition. On average, less than one quarter of patients who have CPR in hospital survive to be discharged home.[1,2]

Enduring Power of Attorney (EPOA)

An Enduring Power of Attorney is a legal document that enables you to appoint another individual to make personal, health and/or financial decisions on your behalf. You can appoint more than one individual. Consider whether it may cause practical difficulties if too many people are expected to be involved in decision-making on your behalf. You can nominate whether each person can make decisions for you independently or whether you want them to make decisions jointly.

Life prolonging treatment

Sometimes after injury or a long illness, the main organs of the body no longer work properly without support. If this is permanent, treatments will be needed to stop you from dying. These treatments are collectively referred to as life prolonging and can include medical care, procedures or interventions which focus on extending biological life without necessarily considering quality of life. Certain life prolonging treatments acceptable to one person may not be acceptable to another.

Statutory Health Attorney (for health/personal matters)

A Statutory Health Attorney is someone with automatic authority to make health care decisions for you if you become unable to make them because of illness or incapacity. You do not appoint a Statutory Health Attorney; the person acts in this role only when the need arises. The first available individual who has a relationship with you and is culturally appropriate becomes your Statutory Health Attorney. Usually this would be your spouse or de facto partner; a person who is responsible for your primary care but not paid to be your carer or a close friend or relative over the age of 18. The Adult Guardian may under certain circumstances become your Statutory Health Attorney.

Substitute Decision Maker

A substitute decision maker is a general term used to describe a person who has legal power to make decisions on behalf of an adult when that adult is no longer able to make their own decisions. You can appoint an individual, while you have legal capacity, using the Enduring Power of Attorney form. If you have not previously appointed anyone and if you are no longer able to make decisions or complete legal documents for yourself then the law provides for a Statutory Health Attorney to speak on your behalf.

1. Morrison, Laurie J., et al. "Strategies for Improving Survival After In-Hospital Cardiac Arrest in the United States: 2013 Consensus Recommendations A Consensus Statement From the American Heart Association." *Circulation* 127.14 (2013): 1538-1563.

2. Girotra, Saket, et al. "Trends in survival after in-hospital cardiac arrest." New England Journal of Medicine 367.20 (2012): 1912-1920.

Statement of Choices

FORM A

(for persons **with** decision-making capacity)

Use this form if you are filling out a Statement of Choices for yourself.

Please complete, sign and return a copy of all three (3) pages.

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Sunshine Coast Hospital and Health Service

Advance Care Planning
Statement of Choices (FORM A)

(Affix patient identification label here OR complete details on page 1)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

My Details

(If using a patient label please write "as above" for this section)

Family Name:

Given Name(s):

Address:

DOB: Sex: M F Medicare No:

My current health conditions include:

I have an understanding of the health impacts of the conditions listed above: *(tick appropriate box).*

Yes No *If you have selected 'No' please consult your doctor before completing this form.*

A. Life Prolonging Treatments

Cardiopulmonary Resuscitation (CPR)

(tick appropriate box)

I **want** CPR attempted if it is consistent with good medical practice **OR**

I **do NOT want** CPR attempted under any circumstances **OR**

Other:

Other Life Prolonging Treatments *e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube*

(tick appropriate box)

I **want** other life prolonging treatments if they are consistent with good medical practice **OR**

I **do NOT want** other life prolonging treatments under any circumstances **OR**

Other:

B. Medical Treatments

I want the following specific treatments to continue to be part of my care if considered to be medically beneficial: *(tick appropriate box(es))*

Major operation Intravenous fluids Intravenous drugs Blood transfusion

Other:

Specific treatments I **do NOT want**: *(tick appropriate box(es))*

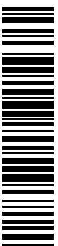
Major operation Intravenous fluids Intravenous drugs Blood transfusion

Other:

proceed to next page...

DO NOT WRITE IN THIS BINDING MARGIN

V2.10 10/2015 Professionally Printed



00049:1599

Advance Care Planning - Statement of Choices (FORM A)

DO NOT WRITE IN THIS BINDING MARGIN

C. Personal Values

The things I most value in my life: *(e.g. independence, enjoyable activities, talking to family and friends)*

Future situations I would find **unacceptable** in relation to my health:

Other things I would like known which may help with future medical decisions: *(e.g. organ or body donation)*

I would like the following person(s) to be included in discussions and decisions about my health care:

If I am nearing death I would like the following: *(including spiritual / cultural preferences)*

The place I would prefer to die:
(e.g. home, hospital, nursing home)

My Declaration

I have had this document explained to me and I understand its importance and purpose. I may complete all or part of this document.

I understand that I can change my mind regarding these choices at any time. **This document will only be used if I am unable to make or communicate decisions for myself.** It will be used by my substitute decision maker(s) and doctors as a guide when making decisions regarding matters of my medical treatment in the future.

I request that my wishes, and the beliefs and values on which they are based, are respected. I understand that doctors should only provide treatment that is considered good medical practice. I also understand that regardless of any decisions about cardiopulmonary resuscitation and life prolonging treatment, I will continue to receive all other appropriate care, including care to relieve pain and alleviate suffering.

I understand that it is important to discuss my wishes with my doctor and my family, including my substitute decision maker(s).

This is a true record of my wishes on this date. I consent to share the information on this form with persons/ services relevant to my health as outlined in the privacy policy available at: www.mycaremychoices.com.au.

Signature: Date:

please turn over...

Sunshine Coast Hospital and Health Service

Advance Care Planning

Statement of Choices

(FORM A)

(Affix patient identification label here OR complete details on page 1)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F

My Substitute Decision Maker(s)

1. List the details of your substitute decision maker:

Name:

Relationship: Home Ph:

Mobile: Work Ph:

This person is my: Enduring Power of Attorney (personal / health matters)
(tick appropriate box) Guardian Nominated person (Statutory Health Attorney)

2. List the details of your alternate substitute decision maker:

Name:

Relationship: Home Ph:

Mobile: Work Ph:

This person is my: Enduring Power of Attorney (personal / health matters)
(tick appropriate box) Guardian Nominated person (Statutory Health Attorney)

My Advance Care Plan Documents

The original Statement of Choices is held by:

This document remains valid until it is changed or cancelled by you or your substitute decision maker.
If desired, you may wish to select a time period for review of this document:

6 monthly 12 monthly Other:

Copies of my advance care plan have been discussed with/given to: *(complete as many lines as applicable)*

1. 3.

2. 4.

Doctor's Review of Plan

I, Dr confirm that

(Registered Medical Practitioner) *(Patient Name)*

is competent and has the capacity necessary to make this Statement of Choices.
I further attest I am not a nominated Enduring Power of Attorney (personal / health matters) to this person or a relation or a beneficiary under this person's will.

Doctor's Signature:

Date:

Hospital or
Practice Stamp

Once completed please sign and send a copy of all three (3) pages of **FORM A** to:
Advance Care Planning, CISAS, Sunshine Coast Hospital and Health Service
Fax: (07) 5313 4284 **OR** Email: SC-ACP@health.qld.gov.au **OR** PO Box 547, Nambour QLD 4560

DO NOT WRITE IN THIS BINDING MARGIN

This resource has been adapted from Austin Health copyrighted publications 2011 by Metro South Health