Advance Care Planning
Record of Advance Care Plans & Preferences

ACP A

Advance Care Planning - Record of Advance Care Plans and Preferences

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

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

Date:

1 INVOLVING OTHERS IN DECISION MAKING

*Have you appointed a **Lasting Power of Attorney**?* Yes ❑ No ❑

Is it for health matters ❑, or financial matters ❑, or both? ❑

Name: **Tel no:**

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

Name: **Tel no:**

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?*

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

*Would you like to go on and discuss your **care around the last days of your life**?*

If not - record: Does not wish to discuss ❑

*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**?*

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...	

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

* You can change the wording of anything below. The statements are just there as a guide.
* 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*
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)		[redacted]	(Complete a DNA-CPR form)

ADDITIONAL INFORMATION

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

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

Does the patient consent to share this information with other healthcare professionals?	❑ YES ❑ NO
Does the patient consent to record this information in their computerised healthcare record?	❑ YES ❑ NO
Has the patient discussed this information with their next-of-kin/family?	❑ YES ❑ NO
Permission to discuss this information with next-of-kin/family if appropriate?	❑ YES ❑ NO

Please record who has been informed:

- ❍ GP
- ❍ District Nurses
- ❍ Out-of-Hours primary care service
- ❍ Specialist Palliative Care Team
- ❍ Hospital Consultant(s) ……..
- ❍ Ambulance Service
- ❍ 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	Date
Signature of care professional helping with form	**Print Full Name**	**Date**