

tō tātou reo advance care planning

My advance care plan

Te whakamahere tiaki i mua te wā taumaha

Plan the health care you want in the future



‘E hono ana tātau ki te whenua mai i te matihe o te ora tuatahi tae noa ki te whakamutunga.

E kawea ana te wairua i roto i te puku o te hau ki te okiokinga o ngā tīpuna.’

‘We are connected to the land from the first breath of life to the last.

Our spirit is carried within the belly of the wind to the resting place of the ancestors.’

Len Hetet (Ngāti Tūwharetoa, Ngāti Maniapoto, Te Ātiawa, Ngāti Apa)

1 | My advance care plan

This is my advance care plan and contains my decisions about my health care and treatment. Please follow this plan if I am unable to tell you what I want.

Last name:

First name:

Date of birth:

NHI:

Address:

Phone:

Mobile:

Email:

Or attach patient label if you have one (ask your doctor or nurse).

For more information about advance care planning go to

myacp.org.nz



2a | What matters to me

This is what I want my whānau, loved ones and health care team to know about who I am and what matters to me.

My cultural, religious and spiritual values, rituals and beliefs:

To honour these beliefs, I want my whānau, loved ones and health care team to:



2b | What worries me

This is what I want my whānau, loved ones and health care team to know about what worries me.

I worry about:

my loved ones because:

suffering. To me this means:

not being able to talk or communicate

not doing things such as:

other things that worry me are:

nothing worries me



3 | Why I'm making an advance care plan

This is why I am making my advance care plan:

I am well.

I am receiving care and treatment for the following:

I understand this may happen to my health in the future:



Facing my future makes me think about:

Facing my future makes me feel:

If my time were limited my priorities would be:



4a Making decisions and sharing information about my health

These scales might help you think about how you like to make decisions and how you prefer your medical information to be shared. Mark along the scale what you would want.

I like to know:

only the basics

all the details about my
condition and my treatment

As doctors treat me, I would like:

my doctors to do
what they think best

to have a say in
every decision

If I had an illness that was going to shorten my life, I prefer to:

know my doctor's
best estimate for how
long I have to live

not know how
quickly it is likely
to progress

How involved do you want your loved ones to be?

I want them to do
exactly as I have said, even if
it makes them uncomfortable

I want them to do what brings
them peace, even if it goes
against what I have said

When it comes to sharing information:

I don't want
my loved ones to know
anything about my health

I am comfortable with
my loved ones knowing
everything about my health

4b If I am unable to make decisions, I would prefer them to be made like this

I want the following enduring power of attorney for personal care and welfare to make decisions using the information in this advance care plan.

Name:

Relationship to me:

Phone:

OR

I don't have an enduring power of attorney.

Using the information in this advance care plan, the following person will help my health care team make the best decisions for me.

Name:

Relationship to me:

Phone:



In addition, the following people know me well and understand what is important to me. I would like them included in discussions about my care and treatment.

Name:

Relationship to me:

Phone:

Name:

Relationship to me:

Phone:

Name:

Relationship to me:

Phone:

Name:

Relationship to me:

Phone:

Name:

Relationship to me:

Phone:

Name:

Relationship to me:

Phone:



5 | When I am dying

As I am dying, my quality of life means:

Other details I would like you to know:

I understand that when I am dying my comfort and dignity will always be looked after. This will include food and drink if I am able to have them.

In addition, I would like you to:

let the people who are important to me be with me

take out things like tubes that don't add to my comfort

stop medicines and treatments that don't add to my comfort

attend to my cultural, religious and spiritual needs, as I described in section 2a.



The place I die is important to me: Yes No

When I am dying I would prefer to be cared for:

at home, which for me is:

in hospital

in a hospital-level care facility (residential care)

in hospice

I don't mind where I am cared for

Other details I would like you to know:



6a My treatment and care decisions

This section is best completed with help from a doctor, nurse or specialist.

Sometimes treatments can be both helpful and harmful. They may keep you alive, but not conscious, or make you feel a bit better for a short time, but cause you pain. Your health care team will only offer treatments you will benefit from.

If I am **seriously ill** and not able to make decisions for myself, the following best describes the care I would like to receive. If I request a treatment that will not benefit me, I understand the health care team will not be required to provide it.

Seriously ill to me means:

Choose only ONE of these five options:

1 I would like my treatment to be aimed at keeping me alive as long as possible. I wish to receive all treatments that the health care team think are appropriate to my situation. The exceptions to this would be:

If required and appropriate I would want CPR to be attempted:

Yes No I will let my doctor decide at the time

2 I would like my treatment to focus on quality of life. If my health deteriorated I would like to be assessed and given any tests and treatments that may help me to recover and regain my quality of life, but **I do not want to be resuscitated.**

For me, quality of life is:

3 I would like to receive only those treatments that look after my comfort and dignity rather than treatments that try to prolong my life. **I do not want to be resuscitated.**

4 I cannot decide at this point. I would like the health care team caring for me to make decisions on my behalf at the time, taking into account what matters to me and in close consultation with the people I have listed in section 4b.

5 None of these represent my wishes.
What I want is recorded in my advance directive on page 6.

I choose option number



6b | My advance directive

If you have treatment and care preferences for specific circumstances or you want an advance directive, please write the details below.

An advance directive is a way of recording, before you need them, specific treatments you would or would not want in different situations if you were no longer able to speak for yourself.

If you can't speak for yourself, it is the responsibility of your health care team to apply your advance care plan and any advance directive. When applying the advance directive, they must be confident that you:

- fully understood what you were asking for
- were free from influence or pressure from someone else
- meant this to apply to the current situation.

In the following circumstances:	I would like my care to focus on:	I would accept the following treatments:	I would wish to refuse or stop the following treatment:
Example: Severe stroke, unable to recognise anyone	Example: Allowing a natural death	Example: Comfort measures	Example: Artificial feeding

If I have left this section blank; I am happy with the choice I made on the previous page and have no other preferences.



6c | Signing my advance care plan

Both typing your name and/or pasting a jpg e-signature are valid ways of electronically signing this document

By signing below, I confirm:

- I understand this is a record of my preferences to guide my health care team in providing appropriate care for me when I am unable to speak for myself
- I understand treatments that would not benefit me will not be provided even if I have specifically asked for them
- I agree that this advance care plan can be in electronic format and will be made available to all health care providers caring for me.

Name:

Address:

Phone:

Email:

Date:

Signature:

TYPE YOUR NAME HERE, OR

PLACE SCANNED SIGNATURE HERE:

Health care professional who assisted me

By signing below the health care professional confirms that:

- I was competent at the time I created this advance care plan
- we discussed my health and the care choices I might face
- I have made my advance care plan with adequate information
- I made the choices in my advance care plan voluntarily.

Health care practitioner:

Facility/organisation:

Designation:

Phone:

Email:

Date:

Signature:

TYPE YOUR NAME HERE, OR

PLACE SCANNED SIGNATURE HERE:

Remember to give copies of your advance care plan to your:

- whānau/loved ones
- doctor or health professional
- enduring power of attorney if you have one.



7 | After my death

My wishes for organ and tissue donation, if appropriate:

My wishes for caring for my body immediately after death:

After I die I would like to be: buried cremated

For my funeral or tangi I would like:



I would like my last resting place to be:

This is important to me because:

I don't mind. I would like the decision to be made by:

Things I would like my loved ones to know:

My will and other important things can be found:



Notes

Karakia

Kua tipu ngā rākau
Kua pūāwai ngā hua
Kua waiata ngā manu
Kua tau te wao
Kua tau, kua tau,
kua tau e
Haumi e, hui e, tāiki e

The trees have grown
The flowers have bloomed
The birds have sung
The forest has settled,
it is settled
Let the peace be amongst us
Let us all be one



myacp.org.nz

tō tātou reo
advance care planning



**Te Kāwanatanga
o Aotearoa**
New Zealand Government

HE3322 | Feb 2020

This resource is
available from
health.govt.nz