



easternhealth
STATEMENT OF CHOICES
COMPETENT PERSON

Page One

UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: ____ / ____ / ____ Sex: M / F

(Affix Hospital I.D. Label if Available)



ACP: STATEMENT OF CHOICES - COMPETENT PERSON EH 002600



F E H 0 0 2 6 0 0 W

I, _____ of _____
 declare that:

1. My current health problems* include _____
2. This document has been explained to me and I understand its importance and purpose. I may complete all or part of this document. It is a guide for my future medical treatment*. It will only be used if I am unable to make decisions for myself, and will be taken into account when determining my treatment.
3. I understand that it is important to discuss my wishes with my doctor, and my family, including the 'Person Responsible' or my Medical Enduring Power of Attorney (if appointed).
4. I request that my wishes and the beliefs and values on which they are based, are respected. I have written on page 2 of this form the things that I value most in life and other things that may help my doctors and other decision makers.
5. I understand that doctors will only provide treatment that might be medically beneficial. I also understand that irrespective of any decisions by the doctor about CPR and life prolonging treatment, I will continue to be cared for, including care to relieve pain and alleviate any suffering.

CPR (Cardiopulmonary Resuscitation) *Initial appropriate box*

A

It has been explained to me by Dr _____ that I would not benefit from attempted CPR and I understand and accept this.

OR

I would like CPR attempted if it might be medically beneficial.

OR

I do NOT want CPR, even if the doctors think it could be beneficial.

AND

Life Prolonging Treatment *Initial appropriate box*

e.g. breathing machine (ventilator), kidney machine (dialysis), feeding tube, surgery

B

I would like life prolonging treatment in order to prolong my life as long as possible

I would like life prolonging treatments only if the doctors expect a reasonable outcome. To me, a reasonable outcome means: _____

I do NOT want life prolonging treatments at all. If life prolonging treatment has been commenced I request that it be discontinued and that I receive palliative care.

OR

C

I choose to delegate decisions regarding CPR and life prolonging treatments to my Medical Enduring Power of Attorney or the following person:

_____ (Insert name of MEPOA and contact number)

OR

_____ (insert name and relationship)

FSG Print Management Tel: 9873 5144 Fax: 9873 5966

* If you have specific health problems you may choose to complete a Refusal of Treatment Certificate which is legally binding (unlike the Statement of Choices which is a guide). Refer to Advance Care Plan Information Sheet.



easternhealth
STATEMENT OF CHOICES
COMPETENT PERSON

Page Two

UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: ____ / ____ / ____ Sex: M / F

(Affix Hospital I.D. Label if Available)

The things that I most value in my life are: (eg. Independence, enjoyable activities, family and friends):

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

Specific treatment that I would NOT want considered for me:

Other things I would like known, which may help with making decisions about my future medical treatment:

I ask that, if possible, my Medical Enduring Power of Attorney and/or family include the following people in discussions and decisions about my health care:

If I am nearing death I would like the following (for example, music, spiritual care, customs or cultural beliefs met, family members present):

This is a true record of my wishes on this date.

My Signature _____ Date _____

Witness' signature _____ Witness name (Print) _____
(preferably Medical Enduring Power of Attorney)

I, Dr _____ believe that _____
 (Registered Medical Practitioner) (your name)

Is competent and understands the importance and implications of this document

Doctor's signature _____

Date _____

The contents of this Statement of Choices have also been discussed with:

Name: _____ Name: _____

Relationship: _____ Relationship _____

Signature: _____ Signature: _____

Date: _____ Date: _____



easternhealth

**ADVANCED CARE PLAN
CONTACT INFORMATION**

UR Number: _____

Surname: _____

Given Name: _____

Date of Birth: ____ / ____ / ____ Sex: M / F

(Affix Hospital I.D. Label if Available)



F E H 0 0 2 5 5 0 1

Name: _____

Address: _____

Date of Birth: _____ Telephone: _____

Medical Enduring Power of Attorney

Name of agent: _____

Telephone no. of agent: _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Name of alternate agent: (if applicable) _____

Telephone no. of agent: _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

If no Medical Enduring Power of Attorney appointed:

Name of Person Responsible: _____

Telephone no. of agent: _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Your Advance Care Plan includes the following documents:

Medical Enduring Power of Attorney Yes / No

Statement of Choices Yes / No

Refusal of Treatment Certificate Yes / No

The original of this Advance Care Plan is held by:

Copies of your Advance Care Plan have been given to:

(complete as many lines as applicable)

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____



