



**easternhealth**

**ACP By Person Responsible  
Statement of Choices**

*Page One*

UR Number: \_\_\_\_\_

Surname: \_\_\_\_\_

Given Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M / F

(Affix Hospital I.D. Label if Available)



F E H 0 0 2 8 0 0



**ACP by Person Responsible: Statement of Choices**

**EH 002800**

This document relates to the following person: \_\_\_\_\_

Of (address) \_\_\_\_\_

I understand that he/she has been assessed as not having legal capacity to appoint a Medical Enduring Power of Attorney or make medical decisions independently.

1. Please note: The law requires that this statement be taken into account when determining treatment for this person. However, unlike a Refusal of Treatment Certificate, the statement of choices is not a legally binding directive to their health professionals.
2. I request that their wishes, beliefs and values on which these decisions are based, are respected. I have written on this form the things that they valued most in life and other things that may help their doctors and other decision makers.
3. 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, he/she will continue to be cared for, including care to relieve pain and alleviate any suffering.
4. 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, he/she will continue to be care 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 he/she would not benefit from attempted CPR and I understand and accept this.

**OR**

I would like CPR attempted on him/her if it might be medically beneficial.

**OR**

I do NOT want CPR for him/her even if the doctors think it could be beneficial.

**AND**

**Life Prolonging Treatments** *Initial appropriate box*

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

**B**

**I would like** life prolonging treatment for him/her in order to prolong their life as long as possible.

**OR**

**I would like** life prolonging treatments for him/her only if the doctors expect a reasonable outcome. By reasonable outcome I mean \_\_\_\_\_

**OR**

**I do NOT** want life prolonging treatments for him/her at all. If life prolonging treatment has been commenced on him/her I request that it be discontinued. I want him/her to be allowed to die naturally, in comfort, with dignity and without pain or distress.



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*Page Two*

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Given Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M / F

(Affix Hospital I.D. Label if Available)

The things that he/she most values are: (eg. Independence, enjoyable activities, family and friends):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Future state(s) of health that he/she would find unacceptable:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific treatment I believe he/she would NOT want:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other things I would like known about him/her which may help with future medical decisions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have hereby made choices based on the best interests of \_\_\_\_\_  
(insert non competent persons name) taking into account their wishes, the wishes of family members and significant others, and the benefits and burdens of treatment. I request that the stated choices recorded are respected by health professionals, now and in the future.

Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to person \_\_\_\_\_ MEPOA/Person Responsible

I, Dr \_\_\_\_\_ believe that \_\_\_\_\_

(Registered Medical Practitioner)

(MEPOA/Person responsible name)

Is acting in the best interest of and on behalf of the person stated above. The MEPOA/Person Responsible understands the importance and implications of this document.

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

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_



**ADVANCED CARE PLAN CONTACT INFORMATION**

UR Number: \_\_\_\_\_

Surname: \_\_\_\_\_

Given Name: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: M / F

(Affix Hospital I.D. Label if Available)

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. \_\_\_\_\_



F E H 0 0 2 5 5 0 1



