My Advance Care Plan

Last name: ____________________________________________________________

First name: ___________________________________________ Date of birth _____ / _____ / _____

Address: _______________________________________________________________

My Advance Care Plan is a record of your advance care planning discussion and a way of informing those who are caring for you of your preferences. Your preferences may not necessarily be health related but will guide your treating health professionals, Enduring Guardian and or family as to how you wish to be treated including any special requests or messages.

Please note: Should you wish to make legally binding treatment decisions, it is recommended that you record these decisions in an Advance Health Directive. You may also wish to give consideration to appointing an Enduring Guardian to make personal, lifestyle and treatment decisions on your behalf. See the Guide for further detail.

I have given a copy of my Advance Care Plan to:

<table>
<thead>
<tr>
<th>Full name</th>
<th>Telephone</th>
<th>Mobile</th>
<th>Relationship to me</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

health.wa.gov.au
I have completed one or more of the following:

**Advance Health Directive**
Yes/No (please circle)
I have stored a copy at: _______________________________________________________
A copy can also be obtained from:
Name: _______________________________________________________
Telephone: _______________________________________________________

**Enduring Power of Guardianship**
Yes/No (please circle)
I have stored a copy at: _______________________________________________________
A copy can also be obtained from:
Name: _______________________________________________________
Telephone: _______________________________________________________

**Enduring Power of Attorney**
Yes/No (please circle)
I have stored a copy at: _______________________________________________________
A copy can also be obtained from:
Name: _______________________________________________________
Telephone: _______________________________________________________

**Will**
Yes/No (please circle)
I have stored a copy at: _______________________________________________________
A copy can also be obtained from:
Name: _______________________________________________________
Telephone: _______________________________________________________
Preferences for my future care

These are my preferences, in relation to my future care. Please refer to the Advance Care Planning Guide for Patients.

Other outcomes of the Advance Care Planning conversation:

For example, you may have considered completing other relevant legal documents such as an Advance Health Directive or Enduring Power of Guardianship or you may have decided to become an organ donor.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
If I have lost capacity or am approaching end of life, where practical and appropriate, I would prefer to be cared for:

Initial the option you prefer:

☐ In my usual home: _________________________________

☐ At a family member’s home: _________________________________

☐ At a hospice or palliative care unit

☐ In hospital

☐ On country (for Aboriginal and Torres Strait Islanders)

☐ At another place: _________________________________

I would like to leave the following message(s)

For example: I am a carer for my partner/family member or I would like the following person to care for my pet, or I would like a particular song played or I would like a particular complementary therapy to be used or I would like my family to respect my preferences to be an organ donor etc.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signed: _____________________________________________ Date: _____ / _____ / _____

This document can be made available in alternative formats on request for a person with disability.