



# **Advance Health Care Plan**





## Advance Health Care Plan

The Advance Health Care Plan (**Your Plan**) tells people how you want to be treated if you are not able to tell people yourself.

### About you

First name

Middle name

Last name

Your address

Suburb

Postcode

Your date of birth

Your telephone number



### People who can speak for me if I cannot speak for myself

I have spoken to the people named below about my plan.

They know what I mean by a good life.

I know they will do as I ask.

They can speak for me if I cannot.



### People who can speak for me if I cannot are:

Name

Phone number

Your relationship to them

Name

Phone number

Your relationship to them

Name

Phone number

Your relationship to them



## Enduring Power of Attorney

An EPoA is a legal document. It names a person who can make decisions for you if you cannot.

It is your choice to have an EPoA

If you have an EPoA they should know about your Advance Care Health Plan.

Name of my Attorney

### I have made an Enduring Power of Attorney.

Phone number



## Guardianship

Some people have a guardian to make decisions on their behalf.

A court says which decisions your guardian is allowed to make.

Sometimes this includes health care decisions.

If your guardian can make health care decisions you should give them a copy of your Advance Care Health Plan.

It will show your guardian what you would do if you were making the decisions yourself.

Name of my Guardian

Phone number of Guardian

### Details of my Guardian



## Your good life

What makes life good is different for everyone.

Write the things that make up your good life in the list below.

### Write the things make up your good life

1.

2.

3.

4.

5.

6.

Please make sure my good life is part of any decisions made if I cannot speak for myself.

Please know that I may already have a disability or illness and still have a good life.

Please value that my good life may not look the same as yours.



## My choices about Life Prolonging Treatments

**Life Prolonging Treatments are treatments you need to stay alive longer.**

Some life prolonging treatments are:

- ventilators
- feeding tubes
- blood transfusions
- kidney dialysis.

There are 4 options about life prolonging treatments.

**You choose 1 option.**

**Put a line through the 3 options you do not want.**

**In the shaded box, Write your initials next to the one you choose.**

Your initials are the first letter of your first name. Then the first letter of your last name.

Write your initials next  
the one you choose.

### **Option 1 - Never**

I do not want any life prolonging treatments.

or

### **Option 2 - Maybe**

Use this space to write when you might want a life prolonging treatment.

I want a life prolonging treatment if :

or

### **Option 3- My doctors decide**

I want a life prolonging treatment if my doctors think I may get well enough to live my good life.

or

### **Option 4 My Enduring Power of Attorney decides**

I have made an Enduring Power of Attorney.

My Attorney can make decisions about Life Prolonging treatments with my doctors.



## My choices about CPR

CPR stands for **Cardiopulmonary Resuscitation**.

CPR can be used if your heart stops. It may get your heart started again.

Your plan needs to show if you want CPR.

There are 3 options for CPR.

Choose only 1.

**Put a line through the 2 options you do not want.**

**In the shaded box, Write your initials next to the one you choose.**

Write your initials in the box next to the option you do want.

<input type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

### Option 1 – Yes

I want CPR

### Option 2 – No

I do not want CPR

### Option 3 – Maybe

I only want CPR if I can get better and live my good life.





## My Health

**Your doctors need information about your health.**

They need this to work out the right options for you if you are very sick or close to dying.

## Chronic Medical Conditions

A chronic medical condition is one that you live with for a long time.

Write down any chronic medical condition you have.

## Life Limiting Illness

Life limiting illness may shorten your life.

Write down any life limiting illness you may have.

**Other things you want known about your health.**

## Statement

I know that this is an important paper.

It tells people how I want to be treated if I cannot tell them myself.

It names people who can speak for me if I cannot speak for myself.

It is only for medical treatment decisions.

I have had the support I need to make my Advance Health Care Plan.

I have had support to understand my Advance Health Care Plan.

The people who have supported me to make this plan are:

I do not have any questions.

I ask that the choices shown in this plan be followed if I am unable to make them for myself.

Please value that my good life experience may not be the same as yours.

Sign your name here.

Today's date is.

Witness signature.

Supporter signature.

**I have given a copy of my advance health care plan to**

1.
2.
3.
4.
5.
6.

My health care team are allowed to see the information in my plan.

**Other documents to include**

1.
2.
3.
4.
5.
6.

I have attached a copy of my Enduring Power of Attorney.  
I have made a Health Direction.



Useful contacts .

Health Care Consumers Association:

<http://www.hcca.org.au>

6230 7800

A.C.T. Disability, Aged and Carer Advocacy Service (ADACAS):

<http://www.adacas.org.au>

6242 5060

Respecting Patient Choices:

<http://health.act.gov.au/public-information/consumers/respecting-patient-choices>

62443344

ACT Public Advocate:

<http://www.publicadvocate.act.gov.au>

6205 2222

Translating and Interpreter Service:

<https://www.tisnational.gov.au>

131450

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