## A B B E Y

MEDICAL CENTRE

Advance Care Plan Recording Your Wishes and Care Preferences

Name:

Date of Birth: / /

NHS number:

**Do you have any special requests or preferences regarding your future care?**

For example: a preferred place of care

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**If your condition changes and you become unwell, where would you most like to be cared for?**

* Your usual place of residence
* Hospital
* A hospice

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there anything you would ideally like to avoid happening to you?**

For example: any treatment you may not wish to receive such as a blood transfusion, or you may not want to be resuscitated

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**Do you have any comments or wishes that you would like to share with others?**

For example: your wish for organ or tissue donation

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**Who else would you like to be involved if it ever becomes difficult to make decisions?**

Preferred contact:

Relationship to you:

Address & telephone number:

**Do you have a Lasting Power of Attorney?**

This only applies if you lose the ability to make these decisions for yourself and is only valid once it is registered with the Office of the Public Guardian

* Yes - If yes, please give a copy to your Doctor/ health or social care professional and keep a copy with this form
* No

**If yes to previous question - Is this a Personal Welfare Lasting Power of Attorney who can make decisions regarding your health and personal welfare?**

* Yes
* No

**Have you made an Advance Decision to Refuse Treatment?**

This is a formally legally binding document which allows a person to refuse certain treatments.

* Yes - If yes, please give a copy to your Doctor/ health or social care professional and keep a copy with this form
* No

**Do you have a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision form in place?** It is normal for patients to plan in case their heart stops. A DNACPR does not affect any other treatment. Patients who are DNACPR can continue to receive all other appropriate treatments.

* Yes - if yes, please keep a copy with this form
* No

**Have you made a will so that your preferences and wishes are known?**

* Yes
* No

**If yes - Do your family members know where this is kept?**

* Yes
* No

**Statement of Your Wishes and Care Preferences -** please confirm this is a true record of your wishes at the time

Your Name:

Signature:

Date: