MARATHON
FAMILY HEALTH TEAM

My Advanced Care Plan

Name: _____ **Date of birth:** _____

Address:_____ **Date completed:** _____

- I have thought about what medical treatment will mean for me and have discussed it with my family, caregivers, and medical practitioners.
- This plan reflects my wishes and details my goals for my treatment and care.
- If I am unable to speak for myself, I have nominated someone to speak on my behalf.

Name of Substitute Decision Maker: (This should be your Power of Attorney for Personal Care if you have one designated) _____

Phone number(s) of Substitute Decision Maker: _____

- Please use this plan to inform how I want to be treated if I can't do so myself.

In addition to this Advance Care Plan, I have also completed an:

Advance Health Directive or Living Will. A copy can be obtained from:

Name:_____

Phone number(s):_____

Power of Attorney for Personal Care. A copy can be obtained from:

Name:_____

Phone number(s):_____

My life goals

These are my specific wishes about what I would like to achieve before I die:

_____

_____

My values about living

These are my thoughts about living when it is unlikely that I will be able to care for myself:

_____

_____

My goals for treatment and care

These are my thoughts and feelings about my care towards the end of my life:

_____

_____

I would like to leave the following special message

This is a special message for:

_____

_____

When I am dying, where possible, I would prefer to be cared for at:

*Initial the **ONE** option you prefer:*

_____ My usual home
_____ A family member's home (specify who) _____
_____ In hospital
_____ Other place (specify where) _____
_____ Undecided

When I am dying, where possible, I would like the following:

*Initial **ALL** the option(s) you prefer:*

_____ Palliative Care (manage my physical, emotional and spiritual needs at end of life)
_____ Stop medications and medical interventions which do not add to my comfort
_____ Cultural/Spiritual practices important to me e.g. _____
_____ Complementary and alternative therapies e.g. _____
_____ I would like to discuss if Medical Assistance in Dying is an option for me

If I become seriously ill, I would like the following life prolonging or comfort measures (see Reference Guide for definitions), if possible:

*Initial the **ONE** option you prefer:*

_____ Full resuscitation to prolong my life (this includes (CPR/defibrillation), and intubation/ventilation)** (WMGH Level 5)

_____ Intubation/ventilation if my breathing becomes too hard, but no CPR/defibrillation** (WMGH Level 4)

_____ Therapy to support my breathing but not intubation/ventilation or CPR/defibrillation** (WMGH Level 3)

_____ Medical therapy and surgical therapy (may involve transfer to another hospital) but no intubation/ventilation or CPR/defibrillation** (WMGH Level 2)

_____ Medical therapy that can be done in my home community/community hospital but no intubation/ventilation or CPR/defibrillation and no transfer to other hospitals** (WMGH Level 1b)

_____ Allow me to have a natural death and provide comfort measures (WMGH Level 1a)

** I understand that if the physician who assesses me at the time determines that possible treatments are likely to be futile (not meaningfully improve my care or life), they may choose not to offer those treatments.

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

Title	Full Name	Phone Number(s)
Doctor		
Hospital		
Family		
Friend/Other		

☐ I have a copy of my Advance Care Plan and provide consent to share this Advance Care Plan with:
☐ Wilson Memorial General Hospital
☐ Marathon Family Health Team
☐ Other (please specify):_____

Signed:_____ Date: _____