

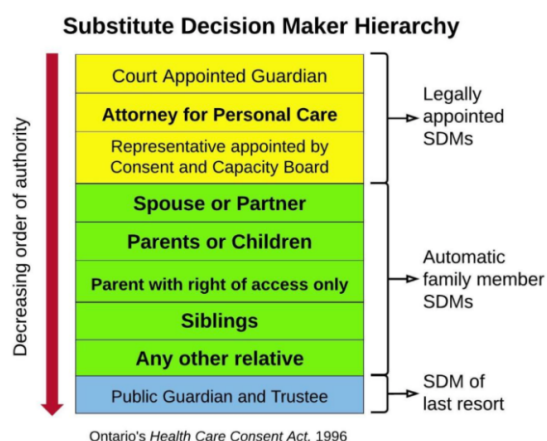
My Advance Care Plan

(March 2023, adapted from <https://advancecareplanningontario.ca>)

Name: _____ Date completed: _____

- I understand that **this document is not legal or binding and I may change my plan at any time**
- I have discussed/or will discuss my wishes for future healthcare with my SDM(s) named below.

1) Substitute Decision Maker(s) (SDM): *(For most people the closest living relative is the SDM unless you complete legal paperwork to choose someone else as Power of Attorney for Personal Care. See chart for legal and automatic SDMs in order.) A SDM will ONLY make your healthcare decisions when you are NOT mentally capable of making a healthcare decision.*



SDM First and last name _____

Type of SDM (See chart) _____

Phone number: _____

Alternate phone: _____

Address: _____

Email address: _____

Location of original document if this person was appointed through a Power of Attorney for Personal Care Name: _____

Phone number(s): _____

Complete below if there is more than one person at the same level of the hierarchy

SDM First and last name _____

Type of SDM (see chart) _____

Phone number: _____ Alternate phone: _____

Address: _____

email address: _____

Location of original document if this person was appointed through a Power of Attorney for Personal Care Name: _____

Phone number(s): _____

If you have more than two SDMs list others below

Name	Type (see chart)	Phone	Power of Attorney? y/n

2) My Wishes and Values: To help my SDM if they need to make decisions for me in the future. The following questions are to help prompt your thinking.

A) I am living with a chronic or serious illness (if healthy skip to section B)

What do I understand about my health or illness?

What have I been told about my illnesses?

What information would I like to find out? (you are encouraged to raise these questions with your healthcare provider)

B) What do I value most? What brings quality or meaning to my life?

Consider this list of values. Which are most important to you?

- ☐ Dignity (What does having dignity mean to you? What comes to mind when you think of losing your dignity?)
- ☐ Independence, not being a burden (What does independence mean to you? What comes to mind when you think about being dependent on others?)
- ☐ Family (If spending time with family is important to you, what is it that makes it so important?)
- ☐ Relationships
- ☐ Wellness
- ☐ Clear-mindedness
- ☐ Other
- ☐ Hard work/dedication
- ☐ Strength
- ☐ Spirituality

What concerns or worries do I have about how my health may change in the future?

What might I trade for the chance of gaining more of what I value or what's important to me (e.g. more time with family)?

If you were near the end of your life, what would make this time meaningful?

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. _____

Even if I am not actively dying, if I have a serious and incurable illness with "irreversible decline", and I am suffering, I may want to consider a medically assisted death.

_____ I would like to discuss if Medical Assistance in Dying is an option for me

I have given a copy of my Advance Care Plan and/or discussed my wishes with the following:

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

I also have written/recorded my wishes and they can be found (provide location/contact information):

I have a copy of my Advance Care Plan and provide consent for Marathon FHT to share this Advance Care Plan with:

- ☐ Wilson Memorial General Hospital
☐ Other (please specify): _____

Signed: _____ Date: _____

Appendix: “Code status” for consideration and alignment with the hospital.

(please feel free to discuss this section with your provider)

If I become seriously ill, I would like the following life prolonging or comfort measures, if possible :

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

_____ Full resuscitation to attempt 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 (“non invasive”)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, and will inform me and/or my SDM why there is no medical benefit

DATE: _____

Patient name: _____

Power of Attorney: _____