	INDOCHINESE ELDERLY REFUGEES ASSOCIATION – VICTORIA INC.	**Advance Care Planning**

Resident Name: …….. Room: …… Facility: ……...

Advance Care Planning has been demonstrated to reduce the burden of decision making during crisis situations and facilitates clearer understand of the resident's wishes for management of both life limiting and life threatening illnesses as well as end of life care.

The purpose of this Advance Care Plan is as a communication tool between you, your representatives and staff to ensure that in all circumstances your wishes are known and upheld. Whilst it is not mandatory to complete this form we strongly advise you to do so.

Person Completing this Plan

☐ Resident ☐ Legal Guardian ☐ Enduring Power of Attorney (Medical)
Name of Person (if other than resident)……..

Do you already have a Documented Plan or Request list for your Management if you have a Life Threatening or End of Life Illness?

☐ Yes (Please attach a copy of your plan/list) ☐ No, please continue

Please indicate your preference for Medical Management by Placing an X in the Box, if the following occurs.

Cardiopulmonary Resuscitation (if I have no pulse and/or I am not breathing

☐ Staff to attempt to resuscitate/CPR

☐ **Do not** attempt resuscitation

Note CPR could include compression to the check which sometimes can result in broken ribs, needles and tubes places in your arms or legs to administer fluids and/or drugs, and tubes put in your throat to assist your breathing. These actions may or may not restore life.

Medical Interventions – if I have a pulse and/or I am breathing:

☐ **Comfort measures only (Allow Natural Death)**
Relieve my pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. I prefer not to be transferred to hospital for life sustaining treatments (Transfer to occur if comfort needs cannot be met by my current location.) Do not hospitalise.
Treatment Plan: Maximise comfort through symptom management.
Or

☐ **Limited Additional Interventions** – in addition to the care as listed above I wish the doctors to use medical treatment, antibiotics, intravenous fluids and cardiac monitoring as indicated. No intubation, advanced interventions or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). I wish to be transferred to hospital, but avoid care in the Intensive Care Unit.
Treatment Plan: Provide basic medical treatments
Or

☐ **Full Treatment:** In addition to the care listed above use Intubation, advanced airway interventions and mechanical ventations as indicated. Transfer to hospital and/or Intensive Care Unit, if indicated. Generally avoid Intensive Care Unit.

Treatment Plan: Full treatment including life support measures in an Intensive Care Unit.

Additional Orders:……
……
……
……
……
……

Do you wish to follow the rites and traditions of any particular faith or religious denomination>

☐ No ☐ Yes(see below)
If yes, please specify:
……
……
……

When the time comes that you are nearing death, please list your preferences for the following:

☐ Enough medication to relieve my pain even if it makes me drowsy or unconscious

☐ I would like people to talk to me and hold my hand even if I do not respond

☐ I would like people to pray with me or for me

☐ People I would like to be present:
……
……
……

☐ I would like the following customs taken in to account:
……
……
……

☐ I would like my favourite music to be played:
……
……

☐ What I particularly do not want is:
……
……
……

☐ Other
……
……

Can we call your primary contact person through the night? __Yes __No

Please advise the name of your preferred Undertaker/Funeral Service
Business Name:
……
Address:
……
Telephone Number:
……

Do you have a pacemaker ☐ No ☐ Yes (if yes please ensure the funeral provider is informed)		
Details of Persons involved in Advance Care Planning Discussion:		
Name:	Relationship to Resident	Date of Discussion

Medical Practitioner

Name: …….. Signature:
…… Date: ……..

Resident/Medical Treatment Decision Maker

Name: …….. Signature:
…… Date: ……..

Independent Person Witness all Signatures

Name: …….. Signature:
…… Date: ……..

File this document in the front of resident's file - this supersedes any Critical Care Wishes or advance care planning.