Statement of Choices

ADVANCE CARE PLANNING

This Statement of Choices can help you record your wishes, values and beliefs to guide those close to you to make health care decisions on your behalf if you are unable to make those decisions for yourself.

www.mycaremychoices.com.au

Queensland Government

Advance Care Planning

If you were suddenly injured or became seriously ill,
who would know your choices about the health care you would want?

What is advance care planning?

Advance care planning (ACP) means thinking about and making choices now to guide your future health care. It is a way of letting others know what is important to you if you could not communicate for yourself. It is a voluntary process which gives you the opportunity to discuss your beliefs and values, and helps give you peace of mind that you can receive the right care, at the right time, in the right place.

Why plan ahead?

- To have your wishes known to help guide the treatment and care you receive in the future
- To let your loved ones know what you would want if they need to make difficult decisions on your behalf
- To allow your choices about health care to be considered before a crisis occurs.

When will your advance care plan be used?

Your advance care plan may only be used if you are unable to make or communicate your own health care decisions.

What if my family member or someone I care for is currently unable to make health care decisions and they do not have an advance care plan?

A Statement of Choices can still be considered for that person. The form should be based on that person's best interests, their expressed wishes and the views of their significant others. It should take into account the benefits and burdens of the person's illness and medical treatment.

Does an advance care plan apply across all health care environments?

Yes, you can give a copy of your advance care planning document(s) to all health care services to allow your wishes to be known and considered. This includes hospitals, community health centres, your GP and any other health facilities you may access.

Steps of advance care planning

Step 1

Discuss with your usual doctor your health conditions and how they may affect you both now and in the future. Discuss with your family your values, beliefs and preferences for future health care.

Step 2

Record your wishes in an ACP document such as the Statement of Choices. You should also record who you may have already appointed to be your substitute decision-maker.

Step 3

Share copies of ACP documents with your family, GP and hospitals. Also send copies to the Office of Advance Care Planning (see page 4 Form A & B) to share your choices with health care providers.

Step 4

Review your preferences and values whenever there are changes in your health or life circumstances and update your ACP document(s) accordingly.

Think now. Plan sooner. Peace of mind later.

Statement of Choices

The Statement of Choices is a values-based document that records a person's wishes and choices for their health care into the future. Although the Statement of Choices is not included in Queensland legislation, the content can still have guiding effect by assisting substitute decision-makers and clinicians if a person is unable to communicate their choices.

Form A is used by people who **can** make health care decisions for themselves.
Form B is used for people who **cannot** make health care decisions on their own.

Legally-binding ACP documents in Queensland

If you have strong wishes about your future health care you should consider completing these legally-binding documents.

Advance Health Directive (AHD)

This is a legally-binding document that states a person's instructions for health care in specific circumstances. It must be completed with a doctor and signed in front of a qualified witness. It can also be used to appoint your substitute decision-maker for health decisions.

Enduring Power of Attorney (EPOA)

This is a legally-binding document that can appoint one or more person(s) to make personal, health and/or financial decisions on your behalf. It must be signed in front of a qualified witness and you can choose how the responsibility of decision-making is shared.

You can obtain a copy of these documents at: www.my**care**my**choices**.com.au

Order of substitute decision-making

In Queensland, when a person is unable to make or communicate their own health care decisions, there is an order of priority for substitute decision-making:

1.	**Advance Health Directive**	A legally-binding document used to give consent and direct medical management in specific health circumstances.
2.	**Tribunal-appointed guardian**	A guardian appointed by the Queensland Civil and Administrative Tribunal (QCAT) to make health care decisions on behalf of a person.
3.	**Attorney appointed under an AHD/EPOA**	A person (known as an "attorney") appointed for personal/health decisions in an Advance Health Directive or Enduring Power of Attorney document.
4.	**Statutory health attorney**	A relevant person who has authority to make health care decisions in the absence of the above decision-makers. See glossary for details.

Statement of Choices may help guide these decision-makers

Contact information

Office of Advance Care Planning:

PO Box 2274
Runcorn QLD 4113

Ph: 1300 007 227
Fax: 1300 008 227

Email: acp@health.qld.gov.au

GLOSSARY OF TERMS

Capacity

Capacity refers to a person's ability to make a specific decision in a particular area of their life. A person has capacity for health care decisions when they can understand the information provided by a doctor about their health and treatment options and are able to make a decision regarding their care. The person also needs to be able to communicate their decision in some way and the decision must also be made of the person's own free will.

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation includes emergency measures to keep the heart pumping (by compressing the chest or using electrical stimulation) and artificial ventilation (mouth-to-mouth or ventilator) when a person's breathing and heart have stopped. It is designed to maintain blood circulation whilst waiting for treatment to possibly start the heart beating again on its own. The success of CPR depends on a person's overall medical condition. On average, less than one in four patients who have CPR in hospital survive to be discharged home.[1,2]

Good Medical Practice

Good medical practice requires the doctor responsible for a person's care to adhere to the accepted medical standards, practices and procedures of the medical profession in Australia. All treatment decisions, including those to withhold or withdraw life-sustaining treatment, must be based on reliable clinical evidence and evidence-based practice as well as ethical standards. Good medical practice also requires respecting adults' wishes to the greatest extent possible.

Life Prolonging Treatment

Sometimes after injury or a long illness, the main organs of the body no longer work properly without support. If this is permanent, ongoing treatments will be needed to stop a person from dying. These treatments are collectively referred to as life prolonging and can include medical care, procedures or interventions which focus on extending biological life without necessarily considering quality of life. Certain life prolonging treatments acceptable to one person may not be acceptable to another.

Office of the Public Guardian

The Office of the Public Guardian is an independent statutory body that protects the rights and interests of vulnerable Queenslanders, including adults with impaired capacity to make their own decisions.

Organ or Tissue Donation

Donation involves removing organs and tissues from someone who has died (a donor) and transplanting them into a recipient who is on a waiting list. Organs that can be transplanted include the heart, lungs, liver, kidneys, intestine and pancreas. Tissues that can be transplanted include heart valves, bone, skin and eye tissue. Organ and tissue donation can save and significantly improve the lives of many people who are sick or dying. For additional information about donation and to register your wishes visit: www.donatelife.org.au

Statutory Health Attorney

A statutory health attorney is someone with automatic authority to make health care decisions for a person if they become unable to do so because of illness or incapacity. This attorney is not formally appointed; they act in this role only when the need arises. The statutory health attorney is the first available, culturally appropriate adult from the following list, in order: a spouse or de facto partner in a close and continuing relationship; an adult who cares for the person but is not employed to be their carer; or a close friend or relative who is not the person's employed carer. The Public Guardian may, under certain circumstances, become the statutory health attorney of last resort.

Substitute Decision-maker

Substitute decision-maker is a general term used to describe someone who has legal power to make decisions on behalf of an adult when that person is no longer able to make their own decisions. This may be: a person appointed in an Enduring Power of Attorney or Advance Health Directive; a tribunal-appointed guardian or a statutory health attorney.

For more information and resources visit: www.mycaremychoices.com.au

1. Morrison, Laurie J., et al. "Strategies for Improving Survival After In-Hospital Cardiac Arrest in the United States: 2013 Consensus Recommendations A Consensus Statement From the American Heart Association." *Circulation* 127.14 (2013): 1538-1563.

2. Girotra, Saket, et al. "Trends in survival after in-hospital cardiac arrest." New England Journal of Medicine 367.20 (2012): 1912-1920.

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Statement of Choices

FORM A

For persons **with** decision-making capacity.

A. My Details

(If using a patient label please write "as above")

Given Names:

Family Name:

Preferred Name: Phone:

Address:

DOB: Sex: ☐ M ☐ F ☐ I Medicare No:

I have the following:

1. Advance Health Directive (AHD) ☐ Yes ☐ No
2. Tribunal-appointed guardian ☐ Yes ☐ No
3. Enduring Power of Attorney (EPOA) (personal/health matters) ☐ Yes ☐ No

If you have a legally appointed substitute decision-maker as per 1, 2 or 3 you should fill in their details below.
If you have not appointed anyone you can still include the details of people you wish to be involved in discussions about your health care decisions in the future.

My Contacts

Name:

Phone: Relationship:

I have appointed this person as a decision-maker in my EPOA or AHD: ☐ Yes ☐ No

Name:

Phone: Relationship:

I have appointed this person as a decision-maker in my EPOA or AHD: ☐ Yes ☐ No

Name:

Phone: Relationship:

I have appointed this person as a decision-maker in my EPOA or AHD: ☐ Yes ☐ No

If there are more than 3 substitute decision-makers please attach details on a separate sheet and tick this box: ☐

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Advance Care Planning - Statement of Choices (FORM A)

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

My name:

B. Personal Values

Describe what you value or enjoy most in your life:
Think about what interests you or gives your life meaning.

Consider what you would like known about you when health care decisions are being made:
Think about your past experiences, wishes and beliefs or what is important to you.

Describe the health outcomes that you would find unacceptable:
*Think about what you would **not** want, including situations you consider may involve severe disability.*

Describe what would be important or comforting to you when you are nearing death:
Think about your personal preferences, special traditions or spiritual support.

Indicate the place where you would prefer to die: *(e.g. home, hospital, nursing home)*

Consider how you would want to be cared for after you die:
Think about your spiritual, religious and cultural practices; organ and tissue donation; and any other wishes that you want noted.

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QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

My name:

C. Medical Conditions

My current medical conditions include:

The health impacts of the conditions listed above have been explained to me and I understand them:
☐ Yes ☐ No *If you have answered 'No' please consult a doctor before continuing with this form.*

Medical and emergency preferences

Please remember, doctors need to speak with the relevant substitute decision-maker(s) at the time a decision is made. You will always receive relevant care to relieve pain and suffering.

Life Prolonging Treatments

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

☐ I **would wish** CPR attempted if it is consistent with good medical practice **OR**

☐ I **would NOT wish** CPR attempted under any circumstances **OR**

☐ Other:

Other Life Prolonging Treatments *(tick appropriate box)*

e.g. kidney machine (dialysis), feeding tube, breathing machine (ventilator)

☐ I **would wish** for other life prolonging treatments if consistent with good medical practice **OR**

☐ I **would NOT wish** for other life prolonging treatments under any circumstances **OR**

☐ Other:

Medical Treatments

If considered to be medically beneficial,	I would wish for:	I would NOT wish for:	undecided / no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐

Other:

please turn over...

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM A)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

My name:

Statement of Choices

This document remains in place until it is updated or withdrawn.
You may indicate a time period when you want to review this document *(optional)*:

☐ 6 monthly ☐ 12 monthly ☐ Other:

My Understanding

I have had this document explained to me and I understand its importance and purpose. This is my true record on this date and I request that my wishes, values and beliefs are respected. I understand that:

- **This document may only be used if I am unable to make or communicate decisions for myself.**
- My substitute decision-maker(s) and doctors may only use this document as a guide when making decisions regarding my medical treatment in the future.
- I may complete all or part of this document and that I can change my mind regarding these choices at any time.
- It is important for me to discuss my wishes with my usual doctor, my family and my substitute decision-maker(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of any decisions about cardiopulmonary resuscitation and life prolonging treatments, I will continue to receive all other relevant care, including care to relieve pain and alleviate suffering.

I consent to share the information on this form with persons/services relevant to my health as per the privacy policy and to non-identifiable information being used for quality improvement/research purposes as per the information sheet. The privacy policy and information sheet are available at: www.mycaremychoices.com.au

Signature: Date:

Usual Doctor's Statement

As a registered medical practitioner, I believe that the person completing this form has the decision-making capacity necessary to complete this Statement of Choices. I am not an appointed attorney in this person's Enduring Power of Attorney or Advance Health Directive, a relation or a beneficiary under this person's will.

Doctor's Name:

Doctor's Signature:

Date:

Hospital or Practice Stamp

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

IMPORTANT: **To allow this document to be available to health care providers, please send a copy of all four (4) pages of FORM A to:**

Office of Advance Care Planning

Fax: 1300 008 227
Email: acp@health.qld.gov.au
Post: PO Box 2274, Runcorn QLD 4113

For more information phone: 1300 007 227

www.mycaremychoices.com.au

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QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Statement of Choices

FORM B

For persons **without** decision-making capacity **OR** requiring supported decision-making.

A. Person's Details

Details of the person for whom this form applies: *(If using a patient label please write "as above")*

Given Names:

Family Name: Preferred Name:

Address:

DOB: Sex: ☐ M ☐ F ☐ I Medicare No:

The person has the following:

1. Advance Health Directive (AHD) ☐ Yes ☐ No
2. Tribunal-appointed guardian ☐ Yes ☐ No
3. Enduring Power of Attorney (EPOA) (personal/health matters) ☐ Yes ☐ No

If a decision-maker for personal/health matters has been legally appointed as per 1, 2 or 3 they should be the one completing this document. If no legal decision-maker has been appointed you can still write the values and wishes of the person to help guide future health care decisions.

Details of Person Completing

Your details, as the person assisting to complete this form:

Name:

Address:

Phone: Relationship:

I have been legally appointed as a decision-maker in an AHD, EPOA or by a tribunal: ☐ Yes ☐ No

Other Contacts

Name: Phone:

Relationship: This person is appointed in an EPOA or AHD: ☐ Yes ☐ No

Name: Phone:

Relationship: This person is appointed in an EPOA or AHD: ☐ Yes ☐ No

If there are more than 3 substitute decision-makers please attach details on a separate sheet and tick this box: ☐

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Advance Care Planning - Statement of Choices (FORM B)

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QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Name of the person **for whom this form applies:**

B. Personal Values

Describe what the person values or enjoys most in their life:
Think about what interests them or gives their life meaning.

Consider what the person would like known about them when health care decisions are being made:
Think about their past experiences, wishes and beliefs or what is important to them.

Describe the health outcomes the person would find unacceptable:
*Think about what they would **not** want, including situations which may involve severe disability for them.*

Describe what would be important or comforting to the person when they are nearing death:
Think about their personal preferences, special traditions or spiritual support.

The place where the person would prefer to die: *(e.g. home, hospital, nursing home)*

Consider how the person would want to be cared for after they die:
Think about their spiritual, religious and cultural practices; organ and tissue donation; and any other wishes that they would want noted.

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QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Name of the person **for whom this form applies:**

C. Medical Conditions

The person's current medical conditions include:

The health impacts of the conditions listed above have been explained to me and I understand them:
☐ Yes ☐ No *If you have answered 'No' please consult a doctor before continuing with this form.*

Medical and emergency preferences

Please remember, doctors need to speak with the relevant substitute decision-maker(s) at the time a decision is made. The person will always receive relevant care to relieve pain and suffering.

Life Prolonging Treatments

Cardiopulmonary Resuscitation (CPR) *(tick appropriate box)*

☐ The person **would wish** CPR attempted if it is consistent with good medical practice **OR**

☐ The person **would NOT wish** CPR attempted under any circumstances **OR**

☐ Other:

Other Life Prolonging Treatments *(tick appropriate box)*

e.g. kidney machine (dialysis), feeding tube, breathing machine (ventilator)

☐ The person **would wish** for other life prolonging treatments if consistent with good medical practice **OR**

☐ The person **would NOT wish** for other life prolonging treatments under any circumstances **OR**

☐ Other:

Medical Treatments

If considered to be medically beneficial,	the person would wish for:	the person would NOT wish for:	undecided / no preference:
A major operation *(e.g. under general anaesthetic)*	☐	☐	☐
Intravenous (IV) fluids	☐	☐	☐
Intravenous (IV) antibiotics	☐	☐	☐
Other intravenous (IV) drugs	☐	☐	☐
A blood transfusion	☐	☐	☐

Other:

please turn over...

Queensland Government

QUEENSLAND HEALTH

Advance Care Planning

Statement of Choices (FORM B)

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth: Sex: ☐ M ☐ F ☐ I

Name of the person **for whom this form applies**:

Statement of Choices

This document remains in place until it is updated or withdrawn.
You may indicate a time period when you want to review this document *(optional)*:

☐ 6 monthly ☐ 12 monthly ☐ Other:

Understanding of the Document

I understand the person for whom this form applies does not have capacity to make independent health care decisions or requires support to make health care decisions. I give my views based on what I believe is in their best interests. I am taking into account their wishes as they are known to me and wishes reported to their significant others and the benefits and burdens of health care treatment as I understand them. I understand the views given in this document are not legally binding but can still have guiding effect.

I request the choices recorded in this document be taken into account by health professionals as part of their application of good medical practice. I also understand that regardless of the choices expressed here the person will continue to receive all relevant care including care to relieve pain and alleviate suffering.

I consent to share the information on this form with persons/services relevant to the health of the person named as per the privacy policy and to non-identifiable information being used for quality improvement/ research purposes as per the information sheet. The privacy policy and information sheet are available at: www.mycaremychoices.com.au

Your Name:

Your Signature: Date:

Usual Doctor's Statement

As a registered medical practitioner, I believe that the person for whom this form applies currently does not have the decision-making capacity necessary to complete a Statement of Choices on their own. I also believe that the person completing this form understands the importance and implications of this document and is acting in the best interests of the person for whom this form applies. I am not an appointed attorney in the Enduring Power of Attorney document or Advance Health Directive, or a beneficiary under the will of the person for whom this form applies.

Doctor's Name:

Doctor's Signature:

Date:

Hospital or Practice Stamp

This form was completed with the help of a qualified interpreter or cultural/religious liaison person: ☐ Yes ☐ N/A

IMPORTANT: **To allow this document to be available to health care providers, please send a copy of all four (4) pages of FORM B to:**

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