

| 1 | Last Name | |
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| | Address | |
| | Phone | . Mobile |
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MY ADVANCE CARE PLAN

(Page 1 of 4)



If you have had a chance to think about the care you want towards the end of your life, you may want to write your thoughts down. Use this plan to write down what you want health professionals, friends and family/whanau to know if you could no longer tell them yourself.

There is a section on medical treatments which is important to discuss with your doctor if possible, before you complete it.

This plan is for you and about you. Complete as much as you want. You can show it to anyone involved in your healthcare. You can add to it as often as you like and change your decisions at any time. Please take it to your doctors or nurses to discuss it and then you can both have copies. It can be forwarded through your doctor to others who may need it, with your consent.



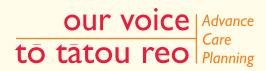


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MY ADVANCE CARE PLAN (Page 2 of 4)

Please use this plan to inform my care only if I am unable to inform you directly.

| My Enduring Power of Attorney (for personal care and welfare) | | | | |
|---|---------------------------------|---------------------|------------------------------|--|
| First name(s): | Last name: | | Relationship: | |
| Address: | | | | |
| Home Phone: | Daytime Phone: . | | Mobile Phone: | |
| | | | | |
| Please try to include the follo | | _ | Dhama | |
| First name: | | · | | |
| First name: | | · | | |
| First name: | Last name: | Relationship: | Phone: | |
| Lhave made a Mill (Hale). | Vaa - Na Itia bald bu | | | |
| I have made a Will (tick): | Yes No It is held by: | | | |
| | | | | |
| If I can no longer tell you my | self I want those who care fo | or me to know: | | |
| The following is important to m | • | - | | |
| TV on, you like to be outside], | ramily concerns, spiritual care | you would like, any | rtning eise you can tnink of | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| This is what makes life meanin caring for you to look after you | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| L would like my family and frien | ids to know and romambar tha | so things: | | |
| I would like my family and frien | ds to know and remember the | se mings. | | |
| | | | | |
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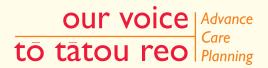


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| | First Name | // DOB |
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MY ADVANCE CARE PLAN (Page 3 of 4)

Please use this plan to inform my care only if I am unable to inform you directly.

| When | am dying the following are important to me (tick): Keep me comfortable Take out tubes and lines that are not adding to my comfort Let my family and friends be with me Offer me something to eat and drink Stop medications that do not add to my comfort Attend to my spiritual needs Other: |
|---------|--|
| | ace I die is important to me (tick): |
| I would | care for my body by ensuring the following: like to be (tick): |
| Ye | d like to donate my organs and/or tissues for transplantation. (tick): Somments: |
| | |



| 1 | Last Name | |
|----|------------|--------|
| | First Name | // |
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MY ADVANCE CARE PLAN (Page 4 of 4)

Please use this plan to inform my care only if I am unable to inform you directly.

Specific Treatment and Care Preferences (please fill out with the help of your Doctor or Nurse)

These expressed preferences should be used to guide clinical decisions in the circumstances I have set out below:

| I would/ would not wan | nt: | In these circumstances: | |
|--|------------|-------------------------|--|
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| For eigneture | | | |
| For signature 1. Lunderstand this is a record of my preferences to guide my healthcare team in providing appropriate care for me | | | |
| I understand this is a record of my preferences to guide my healthcare team in providing appropriate care for me. I understand that it will only be used when I am unable to make decisions for myself. | | | |
| 3. I understand that medically futile and/or inappropriate treatments will not be administered even if this is my expressed preference. | | | |
| 4. I acknowledge that this record may be held in an electronic form and will be made available to other health care providers for purposes of treating me. | | | |
| Signed: | | Date: | |
| Witness (Health Professional): | | | |
| Signed | | Date: | |
| Signed. | | Date. | |
| First Name(s): | Last Name: | Designation: | |