Tips for completing a Statement of Choices Form A:

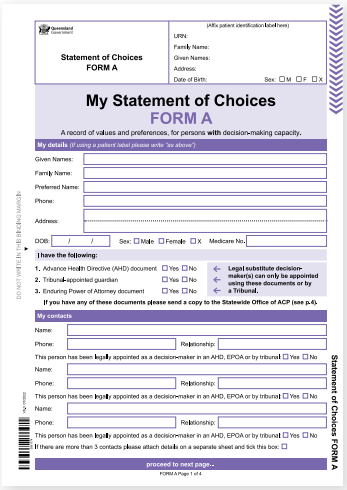
for people who can make health care decisions for themselves

This guide is intended to help you complete a Statement of Choices for yourself. It provides some words other people have used that may help you to get started. The examples here are **not intended to limit or direct** your responses.

To begin completing your Statement of Choices, select Form A and start on page 1.

*Note: Only Form A **OR** Form B should be completed. The decision on which form to use should be based on current circumstances.*

Page 1


Statement of Choices
FORM A

My Statement of Choices
FORM A

A record of values and preferences, for persons with decision-making capacity.

My details (If using a patient label please write 'as above')

Given Names:
Family Name:
Preferred Name:
Phone:
Address:
DOB: / / Sex: ☐ Male ☐ Female ☐ X Medicare No.

I have the following:

1. Advance Health Directive (AHD) document ☐ Yes ☐ No
2. Tribunal-appointed guardian ☐ Yes ☐ No
3. Enduring Power of Attorney document ☐ Yes ☐ No

← Legal substitute decision-maker(s) can only be appointed using these documents or by a Tribunal.

If you have any of these documents please send a copy to the Statewide Office of ACP (see p.4).

My contacts

Name:
Phone: Relationship:
This person has been legally appointed as a decision-maker in an AHD, EPOA or by tribunal ☐ Yes ☐ No
Name:
Phone: Relationship:
This person has been legally appointed as a decision-maker in an AHD, EPOA or by tribunal ☐ Yes ☐ No
Name:
Phone: Relationship:
This person has been legally appointed as a decision-maker in an AHD, EPOA or by tribunal ☐ Yes ☐ No
If there are more than 3 contacts please attach details on a separate sheet and tick this box: ☐

proceed to next page...

FORM A Page 1 of 4

DO NOT WRITE IN THE BLANK SPACES

Statement of Choices FORM A

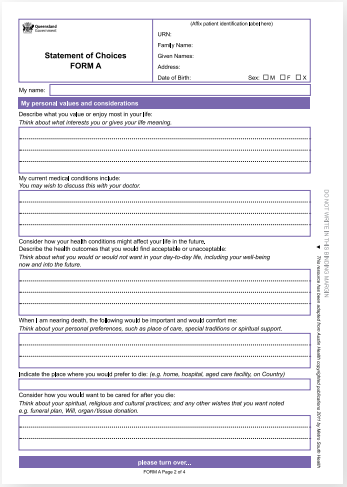
My details: Fill in all blank spaces.

- ✓ "Preferred name" is the name you like to be called.
- ✓ If you live in an aged care facility, please include the name of the facility in the address.
- ✓ Tick the boxes if you have already completed the listed documents.

My contacts:

- ✓ Write names and telephone numbers for each person you have appointed in your Enduring Power of Attorney (EPOA) or Advance Health Directive (AHD) documents or if you have a Tribunal appointed guardian or administrator. Add how they are related to you e.g., husband, daughter, friend.
- ✓ If you don't have an EPOA or AHD, add details of people you would want included in discussions about your health.

Page 2


Statement of Choices
FORM A

(Affix patient identification label here)

URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐ M ☐ F ☐ X

My name:

My personal values and considerations

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

My current medical conditions include:
You may wish to discuss this with your doctor.

Consider how your health conditions might affect your life in the future.
Describe the health outcomes that you would find acceptable or unacceptable:
Think about what you would or would not want in your day-to-day life, including your well-being now and into the future.

When I am nearing death, the following would be important and would comfort me:
Think about your personal preferences, such as place of care, special traditions or spiritual support.

Indicate the place where you would prefer to die: (e.g. home, hospital, aged care facility, on Country)

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

please turn over...

FORM A Page 2 of 4

DO NOT WRITE IN THE BLANK SPACES

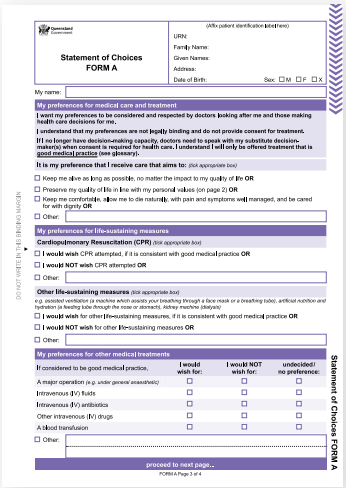
My personal values and considerations:

- ✓ Record what is most important to you and your quality of life.
- ✓ Write as much as possible about the person you are and what your wishes are including any special traditions or spiritual care important to you.
- ✓ Record your medical conditions. It is good to talk to your doctor about your current health conditions and how they might affect your life in the future.
- ✓ Write down the things you want doctors and your substitute decision-maker(s) to know when health care decisions are being made.

Examples of other people's words:

"I love spending time with my grandkids"
"I would like my priest called to comfort my family"
"I love spending time in the garden and listening to music"
"I don't want to be kept alive by machines, just let me die naturally"
"I value being alive more than anything else even if I will be bedbound"
"If I cannot wash, feed or look after myself or talk to my family I do not want to be kept alive"

Page 3


Statement of Choices
FORM A

(Affix patient identification label here)
URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐X

My name:

My preferences for medical care and treatment

I want my preferences to be considered and respected by doctors looking after me and those making health care decisions for me.

I understand that my preferences are not legally binding and do not provide consent for treatment.

If I no longer have decision-making capacity, doctors need to speak with my substitute decision-maker(s) when consent is required for health care. I understand I will only be offered treatment that is good medical practice (see glossary).

It is my preference that I receive care that aims to: (tick appropriate box)

☐ Keep me alive as long as possible, no matter the impact to my quality of life OR
☐ Preserve my quality of life in line with my personal values (on page 2) OR
☐ Keep me comfortable, allow me to die naturally, with pain and symptoms well managed, and be cared for with dignity OR
☐ Other:

My preferences for life-sustaining measures

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 OR
☐ Other:

Other life-sustaining measures (tick appropriate box)

e.g. assisted ventilation (a machine which assists your breathing through a face mask or a breathing tube), artificial nutrition and hydration (a feeding tube through the nose or stomach), Kidney machine (dialysis)

☐ I would wish for other life-sustaining measures, if it is consistent with good medical practice OR
☐ I would NOT wish for other life-sustaining measures OR
☐ Other:

My preferences for other medical treatments

If considered to be good medical practice,	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:			

proceed to next page...

FORM A Page 3 of 4

Statement of Choices FORM A

DO NOT WRITE IN THIS BINDING MARGIN

My preferences for medical care and treatment:

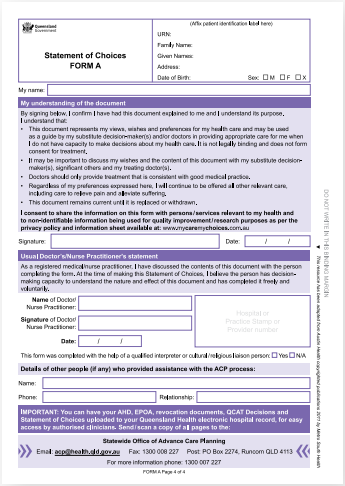
- ✓ Think about the medical care, treatment and goals of care preferences that you would want considered and respected by doctors and those making health care decisions on your behalf.
- ✓ Life-sustaining measures: You may find it helpful to ask your doctor to assist you with this section. Discussing likely treatment outcomes for your current medical conditions may help you to make your preferences known.
- ✓ Medical Treatments: Tick the boxes that indicate your preferences. You may have different preferences for each of the treatment options.
- ✓ For any of the medical treatments, you may choose to write the outcome(s) you would find acceptable in the "Other" box.

Regardless of the preferences expressed on the Statement of Choices you will continue to be offered all other relevant care, including care to relieve pain and alleviate suffering. Doctors should only provide treatment that is consistent with good medical practice.

Examples of other people's words:

"Don't keep going if I am not responding"
"I prefer these treatments only if my quality of life will be improved"
"Please start treatment but discuss with my daughters when it may be time to stop"

Page 4


Statement of Choices
FORM A

(Affix patient identification label here)
URN:
Family Name:
Given Names:
Address:
Date of Birth: Sex: ☐M ☐F ☐X

My name:

My understanding of the document

By signing below, I confirm I have had this document explained to me and I understand its purpose, I understand that:

- This document represents my views, wishes and preferences for my health care and may be used as a guide by my substitute decision-maker(s) and/or doctors in providing appropriate care for me when I do not have capacity to make decisions about my health care. It is not legally binding and does not form consent for treatment.
- It may be important to discuss my wishes and the content of this document with my substitute decision-maker(s), significant others and my treating doctor(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of my preferences expressed here, I will continue to be offered all other relevant care, including care to relieve pain and alleviate suffering.
- This document remains current until it is replaced or withdrawn.

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

Signature: Date: / /

Usual Doctor's/Nurse Practitioner's statement

As a registered medical/nurse practitioner, I have discussed the contents of this document with the person completing the form. At the time of making this Statement of Choices, I believe the person has decision-making capacity to understand the nature and effect of this document and has completed it freely and voluntarily.

Name of Doctor/ Nurse Practitioner:
Signature of Doctor/ Nurse Practitioner:
Hospital or Practice Stamp or Provider number
Date: / /

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

Details of other people (if any) who provided assistance with the ACP process:

Name:
Phone: Relationship:

IMPORTANT: You can have your AHD, EPOA, revocation documents, QCAT Decisions and Statement of Choices uploaded to your Queensland Health electronic hospital record, for easy access by authorised clinicians. Send/scan a copy of all pages to the:

Statewide Office of Advance Care Planning
Email: acp@health.qld.gov.au Fax: 1300 009 227 Post: PO Box 2274, Runcorn QLD 4113
For more information phone: 1300 007 227

FORM A Page 4 of 4

DO NOT WRITE IN THIS BINDING MARGIN

My understanding of the document:

- ✓ Read through the declaration. Sign and date here to show you understand the document and the information it contains.

Usual Doctor/Nurse Practitioner's statement:

- ✓ When you have filled out the document and have discussed it with others who are important to you, ask your doctor or nurse practitioner to sign it. This will make sure they know what your wishes are. The doctor/nurse practitioner can also keep a copy.
- ✓ If you received assistance from someone else to complete this form, list their details here. For example, this could be an advance care planning facilitator or Aboriginal and Torres Strait islander health worker.

When your document is complete:

- ✓ Keep your original document. Give **copies** to your substitute decision-maker(s), doctor and health providers.
- ✓ **send a copy/scan** of all pages to the Statewide Office of Advance Care Planning by email, fax or post (see bottom of p.4), for upload to your Queensland Health electronic hospital record, and easy access by authorised clinicians.
- ✓ You may wish to upload your Statement of Choices to My Health Record.

Review your document:

- ✓ It is good to review all your documents from time to time, especially if your health changes.
- ✓ If you want to change your whole document, fill in a new Form A or for minor changes initial and date them on the form and send the updated one to the Statewide Office of Advance Care Planning for uploading to your medical record.

If, after reading this tip sheet, you would like more information about the Statement of Choices or help to fill it in, please call the Statewide Office of Advance Care Planning on 1300 007 227 for help or to put you in contact with someone in your local area.

An interpreter service is available during office hours to provide information and resources about advance care planning in Queensland.

Call 13 14 50

Interpreter

- State the language spoke
- Ask to be connected to the Statewide Office of Advance Care Planning on 1300 007 227

OACP
Statewide Office of Advance Care Planning