

My Statement of Choices

Choosing your care before the end of life and letting your loved ones know.

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

You can use this Statement of Choices form to write down your wishes, values and beliefs about the care that you would want in the future; to guide those close to you to make health care decisions on your behalf if you are unable to make those decisions yourself.



Torres and Cape
Hospital and Health Service
Consumer Advisory Committee

APPROVED ✓

This document is not legally binding and does not provide consent to health care in advance.

www.mycaremychoices.com.au

Is it ever too early to plan?

Making your wishes known

It is never too early to plan for the end of life. Being prepared is a good thing. Making your wishes about future care you would like to receive is called Advance Care Planning (ACP). It allows your choices about health care to be considered before a crisis occurs.

This means thinking about and making choices now to guide your future health care. It is your choice if you make a plan or not; making one gives you the opportunity to discuss your beliefs and values with your family and your GP and helps give you peace of mind that you will receive the care you want, when you want it and, whenever possible, where you want it.

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

When will my 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 wishes.

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 made for that person. Choices should be based on that person's best interests, their wishes and values 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, with your permission, a copy of your advance care planning document(s) can be shared with health care services to allow your wishes to be known. This includes hospitals, community health centres, your GP and any other health facilities you may access in Queensland.

Steps of advance care planning

Step 1 Yarn



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 Write it down



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 Tell people



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

Step 4 Check & update



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

This document is values-based and records a person's wishes and choices for their health care into the future. Although the Statement of Choices is not included in Queensland law, the content can still have effect by guiding your substitute decision-makers and health professionals if you or your loved one 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)

Enduring Power of Attorney (EPOA)

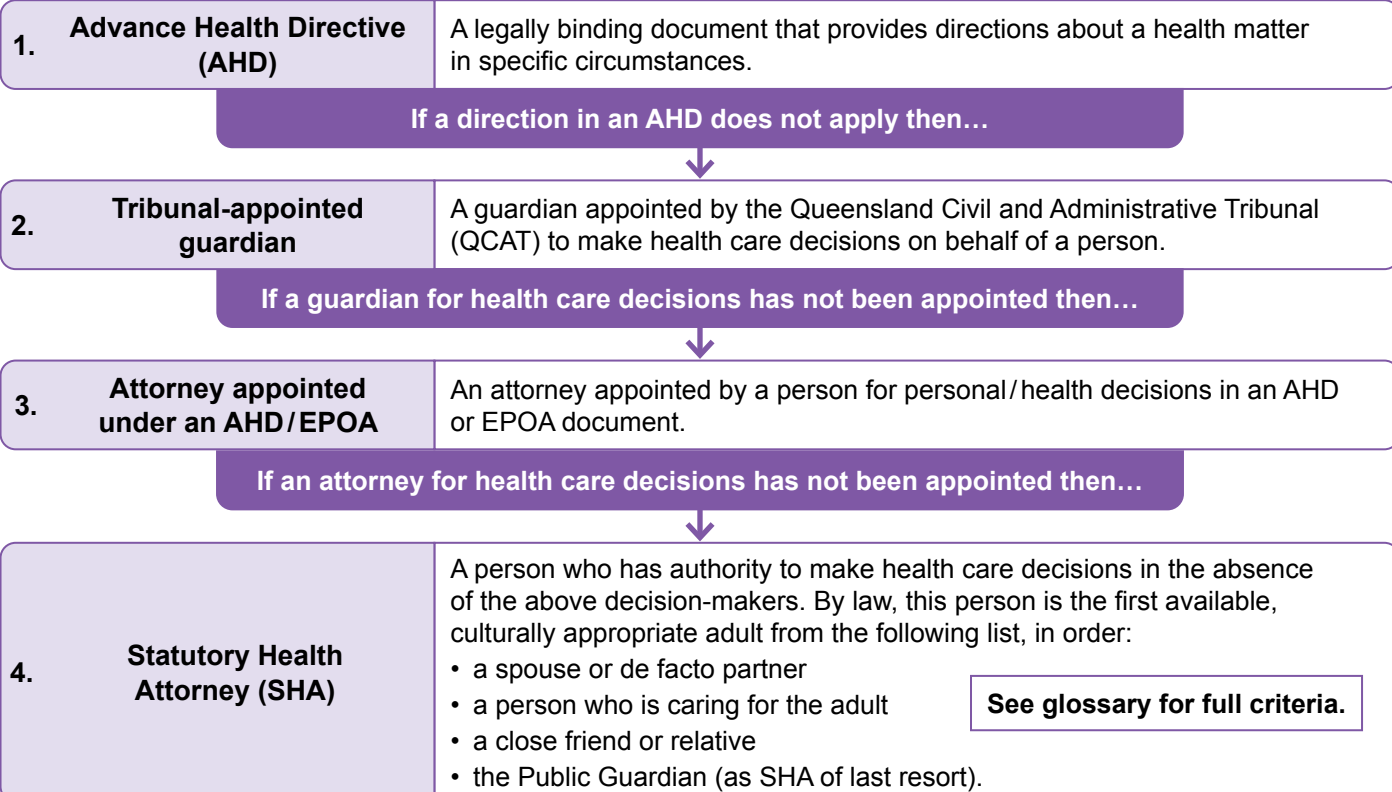
Talk to your Health Worker or GP to find out more.

You can also obtain further information and a copy of these documents at:

www.mycaremychoices.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



See glossary for full criteria.

A Statement of Choices document may help guide these decision-maker(s)

Contact information

Statewide Office of Advance Care Planning: acp@health.qld.gov.au

Phone: 1300 007 227 Fax: 1300 008 227 Post: PO Box 2274, Runcorn QLD 4113

You can also upload document(s) to your My Health Record.**

** See www.myhealthrecord.gov.au

GLOSSARY OF TERMS

Capacity	This legal term refers to a person's ability to make a specific decision in a particular area of their life such as the health care they receive, support services they may need, where they live and how they manage their finances. It is presumed that every adult has capacity to make all decisions until proven otherwise. A person has capacity for health care decisions when they are capable of (i) understanding the nature and effect of decisions about the matter; and (ii) freely and voluntarily making decisions about the matter; and (iii) communicating the decisions in some way. Capacity can change or fluctuate and can be influenced by the complexity of the decision, support available to the person and when the decision is made. For more information visit: https://www.publications.qld.gov.au/dataset/capacity-assessment-guidelines
Cardiopulmonary Resuscitation (CPR)	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.
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 recognised ethical standards of the medical profession in Australia. Good medical practice requires respecting an adults' wishes to the greatest extent possible.
Life-sustaining Measure	The <i>Guardianship and Administration Act 2000</i> defines a life-sustaining measure as health care intended to sustain or prolong life and that supplants or maintains the operation of vital bodily functions that are temporarily or permanently incapable of independent operation. Each of the following is a life-sustaining measure – cardiopulmonary resuscitation, assisted ventilation, artificial nutrition and hydration. A blood transfusion is not considered a life-sustaining measure.
Office of the Public Guardian	This independent statutory body protects the rights and interests of vulnerable Queenslanders, including adults with impaired capacity to make their own decisions.
Organ or Tissue Donation	For information about donation and to register your wishes visit: www.donatelife.gov.au
Statutory Health Attorney (SHA)	This term refers to someone with automatic authority to make health care decisions on behalf of an adult whose capacity to make health care decisions is permanently or temporarily impaired. A person acts in the role of SHA because of their relationship with the impaired adult. By law, this attorney is the first available, culturally appropriate adult from the following: • A spouse or de facto partner (as long as the relationship is close and continuing) • A person who is responsible for the adult's care* • A friend or relative in a close personal relationship with the adult.* Relation can also include a person who under Aboriginal tradition or Torres Strait Islander custom is regarded as a relation • If there is no one suitable or available, the Public Guardian acts as the SHA as a last resort. <i>Note* = This person cannot be the adult's health provider, a service provider for a residential service where the adult is a resident, or a paid carer (although they can be receiving a carer's pension).</i>
Substitute Decision-maker	This term describes 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 document, a tribunal-appointed guardian or a statutory health attorney.
Tribunal	Each State and Territory have an independent, accessible Tribunal that makes decisions on applications about adults who may have impaired decision-making capacity. Their role can include appointment of a guardian for personal/health matters. In Queensland this Tribunal is called the Queensland Civil and Administrative Tribunal (QCAT).

**Statement of Choices
FORM B**

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ X**Statement of Choices
FORM B**A record of understanding of values and preferences of a person **without** decision-making capacity.**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: Male Female X Medicare No.

The person has the following:

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

If decision-maker(s) for personal/health matters have been legally appointed as per 1,2 or 3, they should be completing this document.

If no legal decision-maker has been appointed, you can still record your understanding of the person's values and wishes that may help guide future health care decisions.

Please send a copy of above document(s) to the Statewide Office of ACP (see p.4).**Details of person completing**Your details, as the **person completing this form:** (Note: The person's healthcare providers should not complete this Form)

Name:

Address:

Phone:

Relationship:

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

Other 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

If there are more than 3 contacts please attach details on a separate sheet and tick this box:

PROCEED TO NEXT PAGE...

Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ X

Name of the person for whom this form applies:

My understanding of the person's values and considerations

Describe what the person values and enjoys in life.

Think about what interests them or gives their life meaning.

The person's medical conditions include:

You may wish to discuss this with the person's doctor.

Consider how the person's health conditions might affect their life in the future.

Describe the health outcomes the person might find acceptable or unacceptable:

Think about what they may or may not want in their day-to-day life, including their well-being now and into the future.

When nearing death, the following might be important to the person and comfort them:

Think about their personal preferences, such as place of care, special traditions or spiritual support.

The place where the person might prefer to die: (e.g. home, hospital, aged care facility, on Country)

Consider how the person might want to be cared for after they die:

*Think about their spiritual, religious and cultural practices; and any other wishes that you want noted.
e.g. funeral plan, Will, organ/tissue donation.*

DO NOT WRITE IN THIS BINDING MARGIN

PLEASE TURN OVER...

Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ X

Name of the person for whom this form applies:

My understanding of the person's medical care and treatment preferences

The person would want these preferences to be considered and respected by doctors and those making health care decisions on their behalf. These preferences are not legally binding and do not provide consent for treatment. If a person no longer has decision-making capacity, doctors need to speak with the person's relevant substitute decision-maker(s) when consent is required for health care. It is understood that this person will only be offered treatment that is good medical practice (see glossary).

In my understanding, the person's preference is for care that aims to: *(tick appropriate box)*

Keep them alive as long as possible, no matter the impact to their quality of life **OR**

Preserve their quality of life in line with their personal values (on page 2) **OR**

Keep them comfortable, allow them to die naturally, with pain and symptoms well managed, and be cared for with dignity **OR**

Other:

My understanding of the person's preferences for life-sustaining measures

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

If considered to be good medical practice:

The person **would wish** CPR attempted **OR**

The person **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)

If considered to be good medical practice:

The person **would wish** for other life-sustaining measures **OR**

The person **would NOT wish** for other life-sustaining measures **OR**

Other:

My understanding of the person's preferences for other medical treatments

If considered to be good medical practice,

**the person
might wish for:**

**the person might
NOT wish for:**

**unaware of/
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...

Statement of Choices FORM B

(Affix patient identification label here)

URN:

Family Name:

Given Names:

Address:

Date of Birth:

Sex: ☐ M ☐ F ☐ X

Name of the person for whom this form applies:

Understanding of the document

By signing below, I/we confirm that this document has been explained to me/us and its purpose is understood. I/we understand that:

- The person for whom this form applies has been assessed by a registered medical/nurse practitioner as not having capacity to make their own health care decisions.
- The person has participated to the greatest extent possible to express their views, wishes and preferences. This document represents my/our best understanding of the person's views, wishes and preferences for health care and may be used as a guide by substitute decision-maker(s) and/or doctors in providing appropriate care for this person. It is not legally binding and does not form consent for treatment.
- It may be important to discuss the content of this document with the person's substitute decision-maker(s), significant others and their treating doctor(s).
- Doctors should only provide treatment that is consistent with good medical practice.
- Regardless of the preferences expressed here, the person 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.

Queensland Health may collect, use or disclose information on this form and will do so in accordance with the National Privacy Principles set out in schedule 4 of the *Information Privacy Act 2009 (Qld)*. For more information see the privacy policy and information sheet available at www.mycaremychoices.com.au

Name:

Signature:

Date:

Name:

Signature:

Date:

Usual Doctor's/Nurse Practitioner's statement

As a registered medical/nurse practitioner, following an assessment of the person for whom this form applies, I believe that the person currently does not have the decision-making capacity necessary to complete a Statement of Choices Form A. I am satisfied that the person(s) completing this form understands its nature and effect, has made it freely and voluntarily and is an appropriate person(s) to complete this form.

Name of Doctor/
Nurse Practitioner:

Signature of Doctor/
Nurse Practitioner:

Date:

Hospital or
Practice Stamp or
Provider number

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

Statewide Office of Advance Care Planning

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

For more information phone: 1300 007 227