Think ahead
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SECTION 2. Care Preferences

This section provides key information about you that can be used to inform your medical treatment and care in case of emergency.

This information should be shared with: (Please tick all that apply)

☐ Family ☐ Loved Ones ☐ GP, Nurse, Carer ☐ Other



- **How would you like to be cared for if you were ill?**
- **Who would you like included in discussions about your medical condition or care?**
- **Are there cultural/spiritual preferences or religious beliefs that you would like the healthcare staff to consider in caring for you?**

These are important questions. They can be answered here so that you are given the best possible care and consideration by the staff at a hospital or in another care setting.

This part of the form has three separate sections.

1. The first section deals with your care preferences should you become ill and are unable to communicate your wishes.
2. The second section is an Advance Healthcare Directive. This allows you to set out your preferences about medical treatments you **do not want** to receive in the future in case you cannot communicate your wishes at that time. It also allows you to nominate someone, called a ***Designated Healthcare Representative****, who you have authorised to interpret or make your healthcare decisions. If you have appointed an ***attorney(s)**** under an ***Enduring Power of Attorney**** to make healthcare decisions on your behalf, it is important to state what authority you have given your attorney(s) or ***representative***.*
3. The final section is an emergency summary sheet containing important information. **Remove it from the rest of the form and store it in an easily accessible place for use in an emergency situation.**

We recommend that you speak to a healthcare professional before completing this section of the form as he or she may be the person best placed to give you the information you need when deciding about the care and treatment you would like.

2.1 Care Preferences Communication/Information

There may be some instances when your medical condition may prevent you from being involved in discussions about your health. You might be unconscious, or you might be conscious but unable to understand retain, use, weigh up the information needed to make a particular decision at a specific time or to communicate your wishes. With this in mind:

Would you like a relative, friend, or independent advocate to be present with you for conversations with the medical team, or at key events in your care?

Yes ☐ **No** ☐

** See Glossary*

Need Help?

If at any point you need help completing this form, please visit the Think Ahead website: **www.thinkahead.ie**

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If yes, please give the name and relationship of that person(s):

Name: **Relationship:**

Phone: **Email:**

Name: **Relationship:**

Phone: **Email:**

Care Preferences

If your condition is deteriorating and is life-limiting, who should talk to any children, or other close family and friends, about the extent of your illness and the possibility of your death?

Please Specify...

Cultural/Spiritual Preferences and Religious Beliefs

Are there any cultural/spiritual preferences or religious beliefs or rituals that you would like to be considered as part of your care? If so please list these below:

Is there someone from your cultural community or religious community that you would like to be informed if you are seriously ill? If so please give that person's name and contact details.

Name:

Role:

Phone:

Email:

Keep in Mind

You may change your mind over time and you may also find that when the time comes your preferred place of care may not be available.

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Other Wishes

Think about the place you would most like to be cared for if you were nearing death.

Please indicate your first preference by putting the number '1' beside that option. Likewise, please put the number '2' beside your second preference, '3' beside your third preference and so on. You may change your mind over time and you may also find that when the time comes your preferred place of care may not be available.

- **Home** ☐
- **Hospice** ☐
- **Hospital** ☐
- **Nursing Home** ☐
- **Other (please specify)** ☐

Name of preferred Hospital/Hospice/Nursing Home:

Is there anything in particular (e.g. photos, favourite music, rituals, prayers etc.) you would or would not like in your final days of life? Please list preferences:

What I would like:

What I would not like:

Besides those wishes already expressed, I would like the following requests or preferences to be considered.

2.2 My Advance Healthcare Directive

An ***Advance Healthcare Directive**** (AHD) is a written statement made by a person who has reached the age of 18 years with capacity (the ability to understand, retain and use or weigh up the information in order to make a decision). It sets out their will and preferences about treatment decisions that they **do not want** to receive in the future, if a time comes where they lack capacity to make such decisions or cannot communicate their decision by any means.

The Assisted Decision-Making (Capacity) Act 2015 was enacted in December 2015. It sets out the requirement for making a valid AHD.

AHDs mainly concern a person's right to refuse treatment even if the refusal is considered by others to be unwise, made for non-medical reasons or may result in death, provided that the person at the time of making the AHD had the capacity to make the AHD.

The 2015 Act provides that a request for specific treatment set out in an AHD is not legally binding (a person cannot demand treatment that is unnecessary) but it must be taken into consideration if it relates to treatment that is relevant to the medical condition of the maker of the Advance Healthcare Directive.

If the AHD is valid and applicable (complies with the formalities and specifies the criteria) to the specific treatment then healthcare professionals are legally bound to follow them. An AHD can be revoked or altered in writing provided the person has the capacity to do so. Any alteration of an AHD must be signed and witnessed in the same manner as the original AHD.

An AHD also allows you to nominate a Designated Healthcare Representative. This is an individual who you will authorise to interpret your AHD or to make healthcare decisions on your behalf. They can have such authority as you decide to give them, up to and including the power to consent to/refuse life-sustaining treatment.

There is no obligation to make an Advance Healthcare Directive. It is completely your decision. This section simply assists you in setting out the preferences you may have in a way which will meet the requirements for a valid Advance Healthcare Directive.

Importantly, an Advance Healthcare Directive will come into effect only if you lose *capacity and are unable to communicate your healthcare decisions.**

You may like to either speak to your GP or primary medical professional before completing this or to inform them that you have have completed this and what your wishes are.

Designated Healthcare Representative

If you wish you can appoint a Designated Healthcare Representative. This person may be a trusted family member, close friend or independent advocate who will act on your authority. Therefore, it is important to speak to him or her regarding the care you would like or not wish to have. **You do not have to appoint a representative and can merely set out your wishes in an Advance Healthcare Directive provided the formalities are followed, signed and witnessed by two persons.**

If you decide to nominate a representative, they must be over 18 years of age, not someone who is caring for you in return for payment, and not someone who owns or works in a residential or healthcare facility where you are living. It is necessary for this person to sign the directive and confirm their willingness to act on your behalf.

** See Glossary*

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Your Designated Healthcare Representative

Name:

Relationship:

Address:

DOB: / /

Phone:

Email:

I am willing to to act in accordance with my authority under this Advanced Healthcare Directive

Signature of Designated Healthcare Representative

Alternative Designated Healthcare Representative

(Optional - In the event that the person above is unavailable)

Name:

Relationship:

Address:

DOB: / /

Phone:

Email:

I am willing to to act in accordance with my authority under this Advanced Healthcare Directive

Signature of Designated Healthcare Representative

I have given my Designated Healthcare Representative the following authority:

- ☐ Power to advise and interpret what my wishes are regarding treatment which I have set out in this Advanced Healthcare Directive.
- ☐ Power to ensure that the wishes I have expressed in this Advance Healthcare Directive are carried out based on my will and preferences according to my Advanced Healthcare Directive.
- ☐ Power to consent to or refuse medical treatment on my behalf, up to and including life-sustaining treatment based on my will and preferences according to my Advance Healthcare Directive.

Please state your directives with respect to life-sustaining treatment and ***cardiopulmonary resuscitation**** (CPR) here. These wishes will have an impact if you become unable to take part effectively in decisions regarding your medical treatment.

Life-Sustaining Treatments

Life-sustaining treatment* is treatment which replaces, or supports, a bodily function which is not operating properly or is failing. Where someone has a treatable condition, life-sustaining treatments can be used temporarily until the body can resume its normal function again. However, sometimes the body will never regain that function.

If there is no prospect for my recovery:

☐ I wish to have whatever life-sustaining treatments that my healthcare professionals may consider necessary and appropriate.

OR

☐ I wish to have whatever life-sustaining treatments that my healthcare professionals may consider necessary unless this will require the following treatments, which I do not wish to receive, even if this refusal will result in my death:

- ☐ Being placed on a mechanical ventilator/breathing machine
- ☐ Dialysis
- ☐ Artificial feeding intravenously
- ☐ Artificial feeding through a tube in the nose (nasogastric tube)
- ☐ Artificial feeding through a tube in the abdomen (PEG tube)

There may be some life-sustaining treatments which you would not want to receive in any situation. These may include dialysis, being placed on a ventilator or artificial feeding. If you develop an infection, you may decide not to have *intravenous antibiotics** and also, you may decide not to have oral antibiotics. If there are particular life-sustaining treatments which you do not wish to receive, please mention these below. If you wish to refuse life-sustaining treatment you need to specifically state this and also state that the directive is to take effect even if your life is at risk. **In addition to setting out the specific treatment it is also necessary to specify the specific circumstances regarding the refusal of such treatment, e.g. If I have terminal cancer, I do not wish to receive chemotherapy; If I am in a very serious accident, I do wish to be placed on a ventilator.**

Cardiopulmonary Resuscitation (CPR)

In order to make decisions regarding resuscitation preferences, it is important to discuss your health with your doctor as some conditions will not benefit from CPR.

Please tick your preference:

It has been explained to me by Dr _____

that I would not benefit from attempted CPR and I understand this.

Therefore:

☐ I do NOT want CPR **OR**

☐ I would only like CPR attempted if my doctor believes it may be medically beneficial.

*** See Glossary***

Other Preferences

There may be other situations you would find unacceptable in relation to your health. You can give details here. It is important to specify specific treatments you do not want and the circumstances in which your refusal of treatment is to apply.

This form must be signed by you and by 2 witnesses. Both of these people **must be over 18**, and **at least one of them must not be a member of your family** and should not be your attorney(s) or Designated Healthcare Representative.

Your Signature	Date
Witness 1 Signature	Date
Witness 2 Signature	Date
Your DOB (the directive maker)	

Your wishes may change over time. For this reason we strongly encourage you to review this part of the form annually or as often as is appropriate for you. Please also remember that if you do make any changes to your Advance Healthcare Directive, these must be witnessed in the same way as the original.

Reviews

Signature: _____ Date Reviewed: _____

Signature: _____ Date Reviewed: _____

Signature: _____ Date Reviewed: _____

Signature: _____ Date Reviewed: _____

** See Glossary*

Remember

Irrespective of any decisions about CPR and life-sustaining treatment, you will receive ***basic care****, which will include normal nutrition and hydration as well as care to relieve pain and relieve any suffering.

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2.3 EMERGENCY SUMMARY FORM

This form concerns your preferences for resuscitation and life-sustaining treatment, and is for the attention of paramedics and out of hours providers in case of an emergency.

Patient Name: _____ **Date of Birth:** _____

Address:

Emergency contact persons: _____ **Contact phone numbers:** _____

_____ _____

Location of complete Think Ahead Form:

_____

I have prepared an Advance Healthcare Directive: Yes ☐ No ☐

It can be found: _____

I have nominated a Designated Healthcare Representative: Yes ☐ No ☐

Contact details:

_____

I have appointed an attorney(s) to make healthcare decisions: Yes ☐ No ☐

Note: If the same healthcare decisions are set out in an AHD and an EPA, it will be the AHD document that will be regarded as the valid direction to be followed. The refusal of life-sustaining treatment can only be provided for in an AHD and not in a EPA.

Contact details:

_____

Diagnosis: **Are you receiving ongoing treatment/medication for this?**

1. _____ _____
2. _____ _____
3. _____ _____

Details: **Where do you keep your medications?**

Date Completed: _____ Date Reviewed: _____

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2.3 EMERGENCY SUMMARY FORM

Continued

FOR PARAMEDICS



Resuscitation Preferences;
Please indicate the option(s) most relevant to your present condition.

I understand that I may not benefit from attempted CPR/***defibrillation****, Therefore:

☐ **I do NOT want CPR/Defibrillation to be attempted even if it will result in my death.**

OR

☐ **I would like CPR / Defibrillation to be attempted, if it might be medically beneficial.**

FOR GPs AND OUT OF HOURS PROVIDERS

Key Treatment Decisions
(Please also see above section on resuscitation preferences)

☐ **I would like such life-sustaining treatments that my treating healthcare professionals consider necessary and appropriate.**

Regardless of the preferences expressed above, I understand that in all cases ***basic care**** will be provided.

Any relevant information:

This Think Ahead Emergency Summary Form will guide paramedics and out of hours health professionals in making emergency decisions. It has been developed in association with the Pre-Hospital Emergency Care Council (PHECC) and with input from medical practitioners and legal professionals.

This form must be signed by you.

Your Name: _____ Your Signature: _____

*** See Glossary**