

# My Future Care Plan



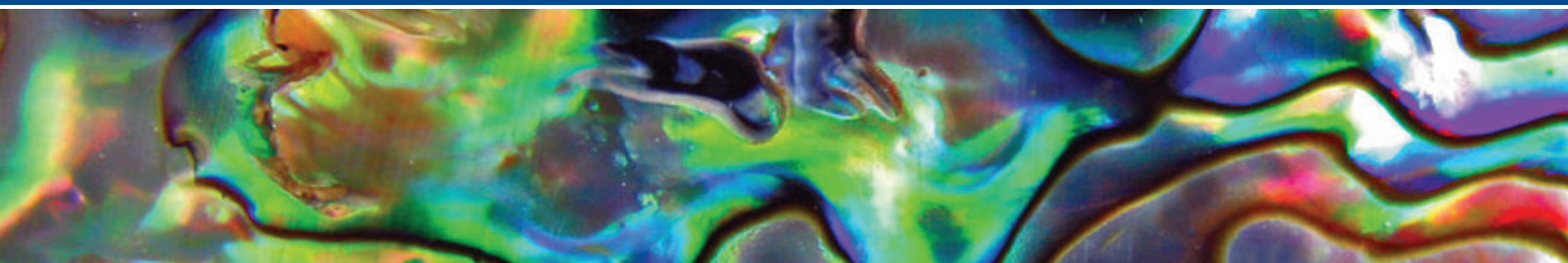
This plan is for you, to use to write down what you would like your friends, family/whanau, and health professionals caring for you to know.

You can add to this as often as you like, and change your decisions at any time. This is **YOUR** plan.

You can write down your wishes and preferences. You can share this with anyone who is involved in looking after you.

You do not have to complete this document all at once.

If you would like help completing this document please speak to someone you trust eg. your GP, health professional, family/friend.



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**Health Providers:** For resuscitation status please see question 5 on pg 7.

This plan is about me and what matters to me

My first name is \_\_\_\_\_

My surname is \_\_\_\_\_

I like to be known as \_\_\_\_\_

I have shared this document with:

- My family / whanau
- My support person
- My GP
- Other \_\_\_\_\_

Date completed \_\_\_\_\_

Reviewed/Updated on \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Updates added and attached at the back of this document.

# My Future Care Plan

## 1. Personal details

a) Date of birth: \_\_\_\_\_

b) My address: \_\_\_\_\_

## 2. Names of people who have helped me with writing this document

\_\_\_\_\_

## 3. My communication

a) My first (or preferred) language is: \_\_\_\_\_

b) I can also use: \_\_\_\_\_ language/s

c) I would like an interpreter  YES  NO

d) I mainly communicate with people using: (e.g. speech, sign language, facial expressions, picture charts, hearing aid, digital diary, electronic communicator, writing). \_\_\_\_\_

\_\_\_\_\_

## 4. Important people in my life:

a) Next of kin (eg. your spouse, family member, relative or a friend)

Full name: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

b) Support person: (eg. your key support worker)

Full name: \_\_\_\_\_

Relationship to me: \_\_\_\_\_

Name of agency: (if applicable) \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

c) GP name: \_\_\_\_\_

Practice name: \_\_\_\_\_

d) Any other person or agency and their contact details:

\_\_\_\_\_

**10. Please try to include the following people in decisions about my care**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ relationship: \_\_\_\_\_ ph: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ relationship: \_\_\_\_\_ ph: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ relationship: \_\_\_\_\_ ph: \_\_\_\_\_

First name: \_\_\_\_\_ Last name: \_\_\_\_\_ relationship: \_\_\_\_\_ ph: \_\_\_\_\_

**6. This is what I want to tell you about myself**

a) Things that I like: (eg. music, food, friends, pets, sport, activities and interests)

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b) Things that I don't like: (eg. spicy food, dark rooms, loud music)

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c) My spiritual needs: (e.g. karakia/prayers, chaplain visit)

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d) My cultural needs: (e.g. I prefer a female doctor, halal food, mirimiri, rongoa, alternative medicine).

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**7. If I can no longer tell you, I want those who care for me to know**

a) This is what makes life meaningful to me (eg. values, people, pets, your spiritual needs, and anything else that you want):

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b) I would like my family and friends to know and remember these things:

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c) These are the things I am concerned about (regrets or worries that I would like to talk to someone about).

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## Advance Directive

1. **I have an Advance Directive (Living Will)** (tick)  Yes  No

An advance directive is a written or oral instruction made by a person in regard to choices about possible future health care procedures. This is in the event they are not competent to make decisions at that time. This advance directive should be taken into account when health professionals are deciding what is in the individual patient's best interests.

I have shared my Advance Directive with: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have discussed my Advance Directive with my GP (tick)  Yes  No

2. **The place I die is important to me** (tick)  Yes  No

3. **If I am dying I would like to be cared for** (tick)

- At home, which for me is \_\_\_\_\_  
 In hospice  
 In hospital  
 Other \_\_\_\_\_

4. **If I am dying the following things are important to me** (tick)

- Let my family and friends be with me.  
 Provide pain medication to ensure I am pain free.  
 Stop medication that is not necessary for my comfort.  
 Remove tubes and lines that are not necessary for my comfort.  
 Offer me something to eat and drink.  
 Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. **If my heart stops beating or I stop breathing** (tick)

- I would like to be resuscitated  
 I would like to be allowed to die naturally

6. **When I die I would like to lie at my local** (tick)

- Marae \_\_\_\_\_  
 Church \_\_\_\_\_  
 Home \_\_\_\_\_  
 Funeral home \_\_\_\_\_  
 Other \_\_\_\_\_

**7. Please care for my body by ensuring the following:**

a) I would like to be (tick):

Buried

Cremated and my ashes to be \_\_\_\_\_

b) I would like the following as my end of life ceremony or funeral:

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c) I would like to donate my organs and/or tissues for transplantation (tick).

*Please be aware you must discuss this with your family as their consent will be required.*

Yes  No

**8. Other comments**

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**9. For signature**

1. I understand that this is a record of my preferences to guide my healthcare team in providing appropriate care for me.
2. This record/document can be used to inform my family and friends of what my wishes and preferences are.
3. I acknowledge that this record may be held in an electronic form and will be made available to other health care providers for the purposes of treating me.
4. I trust that medical professionals caring for me will consider my future care plan.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Witness**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

First Name(s) \_\_\_\_\_ Last Name: \_\_\_\_\_

Designation eg. friend: \_\_\_\_\_



## Updates/Reviews to my Future Care Plan

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Details of any changes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Details of any changes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_

Details of any changes: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Legal documents I have in place

**I have an Enduring Power of Attorney**  
(for personal care and welfare and/or finance)

Yes  No

First name(s): \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

First name(s): \_\_\_\_\_ Last name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**I have made a Will** (tick)  Yes  No

And it is held by \_\_\_\_\_

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