ADVANCE CARE PLANNING FOR INDIVIDUALS AND FAMILIES

HANDBOOK

MODULE 5

TOUCH STONE LIFECARE

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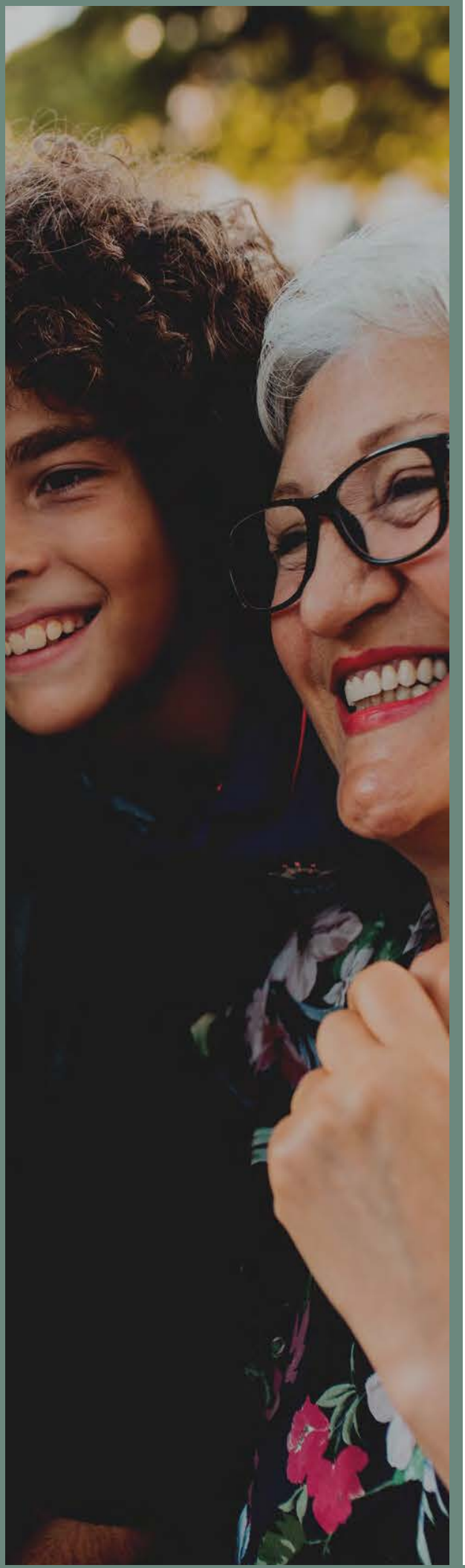
MODULE FIVE

FILLING IN FORMS



INTRODUCTION

Conversations are the core of advance care planning.

But as some stage you will need to capture all the things you have said and share them in a document that can be shared with health and aged care teams.

Otherwise who will know what your most recent wishes and choices are- except the people you spoke with, and they may not be the ones caring for you in an emergency.

In Australia, each state and territory has its own specific rules around what is required for a document to be considered binding.

There are statutory directives in each state. These are the most legally "binding" of any advance care plan or form if correctly filled out and signed.

Some states offer a different advance care plan or values and preferences document in addition to the state directive form. These can be used to add personal flavour and information to help guide other people when planning or caring for you.

You have the choice in how you do your advance care planning, or if you do it at all. You can use your own form or words, or recording. Make sure you get the information you need to make your personal decisions, and to **fully understand the consequences of your decisions**.

Advance Care Plans in Australia

Advance care planning is supported by both statute and Common law in Australia.

Both statutory advance care directives and those made at common law must be considered by a health practitioner when making a decisions about your care or on your behalf.

This is the case in most states and territories in Australia.

You can ensure your wishes, when captured in a document, are more likely to be followed by updatng the document regularly and sharing the document (or documents if there are more than one) with substitute makers and others ahead of time. This is especially important after any major change eg marriage, childbirth, illness.

When people have read your documents ahead of time and discussed them with you, they can later attest that you had capacity at the time to make these decisions, understand them and the consequences of them, and were not coerced by anyone else.

ENDURING POWER OF ATTORNEY FOR HEALTH MATTERS

MEDICAL TREATMENT DECISION- MAKER

ENDURING GUARDIANSHIP

AND MORE...

The other role often discussed around end-of-life planning is your Enduring Guardian, Enduring Power of Attorney for Health Matters, Medical Treatment Decision-Maker, or other similar names.

This is someone you appoint to make lifestyle, health and medical decisions for you when you are not capable of doing this for yourself.

Decisions they make may include where you live, what services are provided to you at home and what medical treatment you receive.

It is a good idea to also name your Enduring Power of Attorney for Health Matters, or your Enduring Guardian, or your Medical Treatment Decision-Maker as your Substitute Decision Maker in your Advance Care plan.

Unless you make an Advance Care Plan, your wishes and directions may not be available to help this person make decisions about you.