

Preferred name

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| 1. **Personal details** | | | | | | | | | | | | | |
| Full name | | | | | | | | | | | | Date of birth | Date completed |
| Address |
| NHS/CHI/Health and care number | | | | | | | | | | | |
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| 1. **Summary of relevant information for this plan (see also section 6)** |
| Including diagnosis, communication needs (e.g. interpreter, communication aids) and reasons for the preferences and recommendations recorded. |
| Details of other relevant planning documents and where to find them (e.g. Advance Decision to Refuse  Treatment, Advance Care Plan). Also include known wishes about organ donation. |

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| 1. **Personal preferences to guide this plan (when the person has capacity)** |
| How would you balance the priorities for your care (you may mark along the scale, if you wish): |
| Prioritise sustaining life,  **Prioritise sustaining life,**  even at the expense  of some comfort  **Prioritise comfort,**  even at the expense  of sustaining life    even at the expense  of some comfort  Prioritise comfort, |
| Considering the above priorities, what is most important to you is (optional): |

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| 1. **Clinical recommendations for emergency care and treatment** | | | |
| Focus on life-sustaining treatment as per guidance below  Clinician signature |  | Focus on symptom control as per guidance below  Clinician signature | |
| Now provide clinical guidance on specific interventions that may or may not be wanted or clinically appropriate, including being taken or admitted to hospital +/- receiving life support: | | | |
| CPR attempts recommended  Adult or Child | For modified CPR  **Child only**, as detailed above | CPR attempts NOT recommended  Adult or child | |
| Clinician signature | Clinician signature | Clinician signature | |
| 1. **Capacity and representation at time of completion** | | | |
| Does the person have sufficient capacity to participate in making the recommendations on this plan? | | | Yes No |
| Do they have a legal proxy (e.g. welfare attorney, person with parental responsibility)  who can participate on their behalf in making the recommendations?  If so, document details in emergency contact section below | | | Yes No  Unknown |

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| 1. **Involvement in making this plan** | | |
|  | 1. This person has the mental capacity to participate in making these recommendations. They have been fully involved in making this plan. | |
|  | 1. This person does not have the mental capacity to participate in making these recommendations. This plan has been made in accordance with capacity law, including, where applicable, in consultation with their legal proxy, or where no proxy, with relevant family members/friends. | |
|  | 1. This person is less than 18 (UK except Scotland) / 16 (Scotland) years old and (please select 1 or 2, and also 3 as applicable or explain in section D below): | |
|  |  | 1. They have sufficient maturity and understanding to participate in making this plan |
|  |  | 1. They do not have sufficient maturity and understanding to participate in this plan. Their views, when known, have been taken into account. |
|  |  | 1. Those holding parental responsibility have been fully involved in discussing and making this plan. |
| 1. If no other option has been selected, valid reasons must be stated here. Document full explanation in the clinical record. | | |
| Record date, names and roles of those involved in decision making, and where records of discussions can be found: | | |

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| 1. **Clinicians’ signatures** | | | | |
| Designation (grade/speciality) | Clinician name | GMC/NMC/  HCPC Number | Signature | Date & time |
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| 1. **Emergency contacts** | | | |
| Role | Name | Telephone | Other details |
| Legal proxy/parent |  |  |  |
| Family/friend/other |  |  |  |
| GP |  |  |  |
| Lead Consultant |  |  |  |

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| 1. **Confirmation of validity (e.g. for change of condition)** | | | | |
| Review date | Designation (grade/speciality) | Clinician name | GMC/NMC/  HCPC Number | Signature |
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