THINKING AHEAD

My Anticipatory Care Plan

PATIENT NAME			
PATIENT ADDRESS			TEL. NO.
CHI NUMBER		DATE OF BIRTH:	

ACCESS TO HOUSE	e.g. key safe number, use back door		
LIVES ALONE?	Yes ☐	No ☐	Details

NEXT OF KIN		**OTHER CONTACT**	
Name:		**Name :**	
Address & Tel. No.		**Address & Tel No**	
Relationship:		**Relationship:**	

GP DETAILS

GP SURGERY		
TEL. NO.		**NHS 24: TEL: 1 1 1**

KEY PROFESSIONAL / SERVICE INVOLVED IN CARE	CONTACT DETAILS	KEY PROFESSIONAL / SERVICE INVOLVED IN CARE	CONTACT DETAILS

RELEVANT MEDICAL HISTORY

ADDITIONAL RELEVANT INFORMATION

(e.g. equipment / drugs / O_2/ relevant social circumstances / communication difficulties)

	Yes	No	Details
Power of Attorney (POA) (see page 3)	☐	☐	
Is there a completed DNA-CPR form? (Question 5)	☐	☐	
Is there a completed Advanced Decision (Living Will) or Advance Statement/ 'Getting to Know Me' form?	☐	☐	
Is there a completed Adult Incapacity form (if required)?	☐	☐	
Has a preferred place of care been identified? (Question 2 & 3)	☐	☐	

It is best to store this plan in a place where it can be easily located when needed (e.g. hospital admission).

I will store my plan: (*e.g. in the drawer under the phone)*

Patient Name:		Date of birth:		CHI Number:	

What is important to me?

This section is about your preferences and wishes. This is not legally binding and you may change your mind at any time.

1. What are the things that are most important to you at the moment, and for the future? e.g. people, places, relationships, personal goals, spiritual or cultural etc.

2. Should your current care arrangements be unavailable (e.g. hospitalisation or illness of your carer / partner) who would you envisage providing the necessary care?

e.g. family, home care, respite care etc.

3. If your condition deteriorates who or what service would you envisage providing the necessary care, and where?

Patient Name:		Date of birth:		CHI Number:	

4. Is there anything, in terms of your health and care, you would not want to happen to you?

e.g. hospitalisation (local or outwith Orkney), tube feeding, etc

5. Do you wish efforts to be made to restart your heart and breathing (*resuscitation*) if you had a sudden collapse (*known as a cardio-respiratory arrest*)?

YES ☐	**NO** ☐	Additional Information:

6. Do you have any comments, wishes or concerns?

POWER OF ATTORNEY(s)			
Name:	**Name:**	**Name:**	**Name:**
Relationship:	**Relationship:**	**Relationship:**	**Relationship:**
Address:	**Address:**	**Address:**	**Address:**
Telephone No:	**Telephone No:**	**Telephone No:**	**Telephone No:**
Finance / Welfare or Both?	**Finance / Welfare or Both?**	**Finance / Welfare or Both?**	**Finance / Welfare or Both?**

Patient Name:		Date of birth:		CHI Number:	

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Consent

To ensure a consistent approach to your care and so that your wishes are known to those looking after you, a copy of this form will be shared with your GP and other practitioners agreed with you who are involved in your care. The form will be stored in your GP electronic medical record.

Your GP practice can make the important aspects of this record electronically available to NHS24. If you are admitted to hospital, this summary will also be electronically available to those looking after you in the hospital. Below is the document summary which, our GP will make available to NHS24 and any hospital you are admitted to.

If you consent to this information being electronically shared, please sign and complete the following section:

Patient Signature	**Date:**
Next of Kin or Power of Attorney Signature (*if present)*	**Date:**

Completed by:	**Designation:**
Signature:	**Date:**

Reviewed On: (Date)	**Reviewed by:**		
	Name	**Designation**	**Signature**

Remember to regularly review whether this document still represents your wishes. Please sign and date any changes you make, and inform:

_____