Patients Name : Date of Birth:

Address: Usual GP:

If filling the form on patient’s behalf please advise Name/relationship:

Power of attorney( circle which applies): YES/NO

1)If you or your relative/friend had a sudden collapse (such as from a stroke or a heart condition) what do you think you or your relative/friend would wish to happen? Tick box which applies below.

|  |  |  |
| --- | --- | --- |
| A) | Be kept comfortable, treat any pain or other symptoms and be cared for in the care home |  |
| B) | Contact family member to help us decide whether to send to hospital instead of dialling 999 for an ambulance and sent to hospital |  |
| C) | Send to hospital for investigations and treatment such as drips and treatment given into a vein |  |

2)If you or your relative/friend had a serious infection that was not improving with antibiotic tablets or syrup what would you or your relative/friend wish to happen?

|  |  |
| --- | --- |
| A) | Be kept comfortable, treat any pain or other symptoms and be cared for in the care home |
| B) | Contact family member to help us decide whether to send to hospital instead of dialling 999 for an ambulance and sent to hospital |
| C) | Send to hospital for investigations and treatment such as drips and treatment given into a vein |

3)If you or your relative/friend was not eating or drinking because you/they were now very unwell, what do you think you or your relative/friend would wish to happen?

|  |  |
| --- | --- |
| A) | Be kept comfortable, treat any pain or other symptoms and be cared for in the care home |
| B) | Contact family member to help us decide whether to send to hospital instead of dialling 999 for an ambulance and sent to hospital |
| C) | Send to hospital for investigations and treatment such as drips and treatment given into a vein |

We would normally share the information in an Anticipatory Care Plan with out of hours and emergency services which can be accessed if help from them is needed.

If you DO NOT wish this information to be shared in this way, tick here

Please circle below:

Patients /Residents/Relatives/Friend Signature: Date:

Nurse signature (If in Care Home): Date: