

Advance Care Plan

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

Te Wa Aroha / Allow Natural Death

Te Wa Aroha / Allow Natural Death and providing palliative care does not indicate a withdrawal of care, but the provision of symptom management; psychosocial, cultural and spiritual support and comfort during the end of life period".

Primary Consultant _____ Date: _____

A discussion about end of life care and allowing a natural death in relation to _____ (name of child) whose diagnosis is _____

was held on _____ (date). The following people were involved in the discussion:

The following goals of care were identified:

Management Plan

Psychological / Social / Cultural / Spiritual support



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Acute Deterioration Measures

In the event of an acute deterioration, the care to be provided may include, as appropriate:

Response	Yes	No	Comments
Call to arrest team			
Nasopharyngeal suctioning			
Oxygen – passive			
Oxygen – bag and mask			
Intubation			
Cardiac compression			
Electrical cardioversion			
Arrest medications			
Antibiotics			
Other (specify)			
When at home - Call Ambulance Service			

Is a referral to the Palliative Care Team needed for symptom management and or psychological / social or spiritual support of the child and family?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, has the referral been made?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

This reflects the care options we have discussed and agreed on.

We understand that we can change these decisions at any time.

We agree that the Advance Care Plan be reviewed in (timeframe _____)

Senior Medical Officer or Senior Nursing or Allied Health Staff completing this form

Print Name _____ Designation _____

Signature _____ Date _____

Contact Number _____

This advance care plan must be reviewed by the agreed time with a new form completed and placed in the clinical record

Fax completed [to follow - CR number] ACP form with CR0008 - Clinical Alert Notification/Cancellation form to the Clinical Record Department for scanning

Place original ACP into child's clinical notes

Copy of ACP sent to GP

Copy of ACP given to family

Copy of ACP sent to St John's Ambulance service email: PCPN@stjohn.org.nz

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