醫院管理局 HOSPITAL AUTHORITY	**Advance Care Planning (ACP) For Mentally Competent Adult** (Original copy to be kept by the patient)	*Please affix gum label with address* Name: Sex/Age: ID No.: Ward/Bed: HN: Dept.:

Points to note:

1. *This document is a record of my wishes and preferences. It helps the health care team understand what matter most to me and guide the future medical care and treatment. It is not a record of my advance decisions and is not legally binding.*
2. *If I wish to document my advance decision for refusal of any specific treatment, I have to sign an Advance Directive (HA-short AD form or HA-long AD form), which will be a legally binding document.*
3. *The health care team is not obliged to provide medically futile or inappropriate treatment irrespective of my preferences.*
4. *I may choose NOT to complete any particular items within sections 5 to 8.*
5. *If I change my preferences, I should discuss with my health care team and my family, and fill in a new ACP form.*

(1) Medical condition

Diagnosis

☐ **Prognosis has been explained to the patient**

Remarks (if any):

☐ **Treatment plan has been explained to the patient**

Remarks (if any):

(2) Doctor involved in ACP

Signature of doctor: _____ **Date:** _____

Name: _____ **Hospital/Department:** _____

(3) Other healthcare professionals involved in ACP

Name	Department/Hospital	Discipline

(4) Family members involved in ACP (please mark: *main caregiver, #living together)

Name	Relationship with Patient	Contact No.

(5) My (patient's) values, beliefs and wishes

Things valuable to me: (e.g. family, functional independence, spiritual or religious belief, legacy, funeral, pets, etc.)

Things worrying me: (e.g. dying in pain, unpleasant past medical experience, unfinished business, being a burden, lingering death, aftermath, etc.)

My wishes or personal goals that I would like to share with others:

(6) Designated family member for future consultation

☐ Yes (please specify) _____ ☐ No

(7) My(patient's) preference for personal care

If my **life expectancy is less than one year**, my preferred place of care is:

☐ Own home ☐ Moving to live with others ☐ Residential care home ☐ Others _____

Potential barriers (e.g. finance, availability of day-time/night-time caregivers, etc.) to preferred place of care:

Other preferences of my personal care are: (e.g. my favourite food, companion, appearance, personal hygiene, social activities, hobbies, etc.)

When I am in my **last days of life**, my preferred place of care is:

☐ Own home ☐ Moving to live with others ☐ Residential care home ☐ Hospital

☐ Others _____

Potential barriers (e.g. finance, availability of day-time/night-time caregivers, etc.) to preferred place of care:

Other preferences of my personal care are: (e.g. rituals, religious activity, music, presence of family/friends, etc.)

(8) Preferences regarding limits on life-sustaining treatments[1]

(a) When I am **terminally ill**[2]:

☐ I prefer not to receive life-sustaining treatments if possible.

☐ I prefer life-sustaining treatments even if the chance of success is low.

☐ My overall preference is between the above two. My specific preferences, if any, are indicated below.

- In addition to my advance decision specified in my AD (if any), my specific preferences (which are not legally binding) for life-sustaining treatments are as follows:

Prefer not to receive:	Not sure of the following:	Accept the following when needed:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ Not decided yet.

(b) When I am **in other end-stage clinical conditions** (please specify):

[1] "Life-sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration.

[2] "Terminally ill" means suffering from advanced, progressive, and irreversible disease, and failing to respond to curative therapy, having a short life expectancy in terms of days, weeks or a few months; and the application of life-sustaining treatment would only serve to postpone the moment of death.

(9) AD and/or DNACPR form for non-hospitalized patients

☐ I have not decided to sign any AD yet

☐ I have signed an AD:

- ☐ HA-short AD form for refusal of CPR, date _____
- ☐ HA-long AD form, date _____
- ☐ Other AD form which is considered valid, date _____

☐ HA DNACPR form for non-hospitalized patients is in place, date _____

☐ HA DNACPR form for non-hospitalized patients is **NOT** yet in place

(10) My (patient's) signature

I acknowledge the above contents.

Signature of patient: _____ **Date:** _____

Name of patient: _____