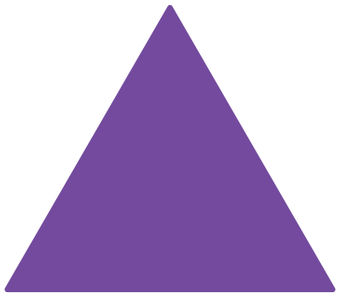

Advance Care Plan

Name: _____

ADVANCE CARE PLAN

(This is a person's care preferences document, and is NOT LEGALLY BINDING)

ALL THE SECTIONS BELOW ARE TO BE FILLED IN BY THE PERSON WHO IS DRAWING UP THE ADVANCE CARE PLAN. HE/SHE MAY SEEK SUPPORT FROM RELATIVES / SIGNIFICANT OTHERS / THE DOCTOR / OR OTHER HEALTH PROFESSIONAL

Name and Surname:	**Form No:** **Update:**
ID:	DOB:
Address:	
Phone:	Date:

Disclaimer: For the attention of the Person (Patient/Client) filling in their Advance Care Plan

- An Advance Care Plan is an expression of your personal values and wishes, which is drawn up to empower your participation in end-of-life care decisions, if, or when, you lose your mental abilities to take decisions. It is also intended to help guide Clinicians and Family Members (or significant others) decide on your behalf if you, the Person, are not mentally capable to take decisions.
- In addition, you are being given the opportunity to identify individuals whom you trust to be involved in discussions about your end-of-life care (page 2).
- Be aware that this document is not legally binding, but rather an expression of your preferences and wishes for your future care, should you be unable to express such preferences, or take decisions regarding your end-of-life care. Your wishes will be adhered to as far as it is practical to do so, but alternative decisions that are deemed to be in your best interests medically or socially, will prevail
- You are not obliged to fill out all the questions listed below, and you have the right to change your preferences in the future, or even withdraw this document if you so wish.

Note: *Many questions in this Advance Care Plan Form do concern complex medical decisions. It is thus advisable to fill out Sections D,E,F,G, H, I, and J with the assistance of the Multidisciplinary Team, who are requested to countersign your preferences as witness at the end of this document.*
- Throughout this document, you will find some sample responses and/or questions to help you think and identify what you want in your Advance Care Plan. These sample responses are not meant in any way to sway you in one way or another from what you want for yourself.
- For your benefit, there is available both a Maltese and English version of this form on the GMS website
- For best use of this document, keep a copy for yourself, give a copy to a Relative or significant other that you trust, and ideally a copy should be kept in your Personal/Hospital Medical File
- For further information visit: ***gmsmalta.com*** *to access Support Leaflets on Advance Care Planning. Clinicians Information leaflets are also available for Health Professionals on the GMS website.*
- Contact with the Advance Care Planning Working Group can be done on: ***acpwg.mt@gmail.com***

A. Indicate below who is present with you, whilst filling in your Advance Care Plan

B. Presence of previous Advance Care Plans

Did you ever fill in before any other Advance Care Plan? *Use a mark (X) to indicate your answer below.*		
Yes	No	Not Answered / Do not Remember
Note: *Once you fill in and sign this Advance Care Plan, all previous forms will be superseded by this one.*		

C. Below provide the details of the individual(s) whom you would like to be involved in deciding on your behalf with respect to your personal care and welfare, should you be unable to do so yourself:

Note: *Place an* ***(X)*** *in the box on the right to indicate if any individual(s) listed below are in possession of your Guardianship or Lasting/Enduring Power of Attorney (see Act XX of 2016, Article: 1864A, of the Civil Code. Malta)*	**X**

1. Name and Surname		
ID	Phone/Mobile no:	
Relationship		
Address		

2. Name and Surname		
ID	Phone/Mobile no:	
Relationship		

3. Name and Surname		
ID	Phone/Mobile no:	
Relationship		

Note to the Person filling out this Form: *Sections D, E, F, G, H, I, and J involve medico-legal decisions. It is advisable to fill out these sections with the help of your Doctor or other Health Professional.*

Note to the Doctor: *Start this part by explaining to the Person what is an Advance Care Plan and what are the possible implications it can have on future care once decisional capacity is lost (use examples in D1 and D2, below). Afterward, proceed by starting to ask the questions in Section D. The answers given by the Person for D1 and D2 indicate if he/she has understood what is an Advance Care Plan. If it is clear that the Person has not understood what is an Advance Care Plan, in such cases, the Multidisciplinary Team needs to evaluate if it is indicated or not, to continue assisting the Person in the drawing up of this Plan.*

D. After careful consideration, you have made the decisions hereunder:

D1. Why are you filling out this Advance Care Plan? *(e.g. I do not want to be a burden on others, I want to leave a message to those I love, I want my wishes known regarding the care for my end-of-life, I want to get my affairs in order)*
D2. When in your end-of-life you are unable to decide for yourself. Once this document comes in the hands of your Doctor and Relatives, what do you wish them to do with it? They give attention to what you wrote and use it in their decisions, or they disregard it? *(e.g., I want that my wishes on the Advance Care Plan be considered as my opinion of what I desire when I am no longer able to decide for myself; I would wish that they be respected)*
D3. What does severe pain mean to you? Can you tolerate it, or are you afraid of severe pain?
D4. What does severe suffering mean to you? *(e.g. Unbearable psychological/emotional/ spiritual distress, severe anxiety, loss of will to live, abandonment in the end-of-life)*
D5. What makes you happy?
D6. How would you want your Family and Friends to remember you after you pass away?

Write down the name of the Specialist Doctor/GP/other Health Professional/s whom you would like to take care of you:	

E. A discussion concerning the Person's current Medical Problems and the agreed Care Plan

Note to the Multidisciplinary Team: *It is recommended that prior to filling out an Advance Care Plan, there should first be carried out a discussion between the Multidisciplinary Team and the Person (+/- Relatives), on the medical problems that are present. This should be accompanied by a discussion on the current agreed Care Plan. If the Person is not aware or does not want to be informed about his diagnosis/prognosis, the Multidisciplinary Team needs to evaluate if it is indicated or not, to continue assisting the Person in the drawing up of this Plan.*

List the Person's Active Medical Problems, Survival estimate (if known) , an appreciation of the General Prognosis, and Treatment Goals
The current Plan of Care agreed between the Person (+/-Relatives) and the Multidisciplinary Team

Mark your answer/s below with an (X)

F. <u>CAPTION: IN REFERENCE TO A SPECIFIC END-OF-LIFE SITUATION</u>:

The Sections that follow all concern a situation that you might find yourself in the future. In other words, a situation where you are close to your end-of-life (close to dying and receiving terminal care), where there is no chance for improvement or recovery, and at the same time, you are unable to decide for yourself.

G. <u>In the situation in caption (Section F), in which place of care would you want to live your last days of life, and eventually die?</u>

Care Needs	***Personal wishes***			
	Yes	No	Do not know / Not Answered / Not Applicable	I'll leave this in the hands of the Doctor / Relatives
Cared for at my own Home				
Cared for (admitted) in a Nursing Home				
Cared for in the Nursing Home I am living *(in the place, room, I am currently staying)*				
Referred to Hospital if it is advised to do so by Doctors				
Admitted to a Specialised Palliative Care Ward / Hospice				

H. <u>In the situation in caption (Section F), would you prefer care that disproportionately prolongs life even at the cost of additional discomfort, or would you prefer an end-of-life with dignity, where what is most important is to avoid unecessary pain and suffering?</u>

Medical Situation in the End-of-Life	***Personal wishes***			
	Yes	No	Do not know / Not Answered	I'll leave this in the hands of the Doctor / Relatives
I would not wish to receive treatment that disproportionately prolongs my life. I would wish instead to recieve care that keeps me comfortable and pain-free, as advised by my Doctors				
I would want life prolonging care at the cost of additional discomfort, as advised by my Doctors				

I. In the situation in caption (Section F), if you have persisting severe difficulty to eat food and drink by mouth, your preference is to:

Medical Decision	***Personal wishes***			
	Yes	No	Do not know / Not Answered	I'll leave this in the hands of the Medical Team / Relatives
Eat and drink whatever little I can by mouth, as comfort food, under the guidance of the Medical Team caring for me. Comfort food does concern an element of risk during swallowing				
Receive artificial feeding and hydration via a feeding tube (NG/RIG/PEG), which can disproportionately prolong my life and lead to additional discomfort, under the guidance of the Medical Team caring for me				
I wish that comfort food is given with the use of subcutaneous fluids, under the guidance of the Medical Team caring for me				

J. In the situation in caption (Section F), you would prefer to:

Medical Decision	***Personal wishes***			
	Yes	No	Do not know / Not Answered	I'll leave this in the hands of the Medical Team / Relatives
Be given only medications to keep me comfortable and pain-free				
Avoid blood tests or other investigative interventions				
Avoid as much as possible to have tubes attached to me				
Avoid extraordinary end-of-life procedures, including CPR				

K. Your Dying and Funeral preferences

When I am dying I would like the following individual(s) around me: *(e.g. Family Members/Friends)*
My preference regarding Administration of Last Sacraments (AOS) / End-of-Life Rituals of my Religion:
I would like to donate my organs: *(to register for organ donation, go to:* ***organdonation.gov.mt***
I would like to donate my deceased body to science: *(to register for donation of your body to science, write to:* ***www.um.edu.mt/ms/anatomy***
My preferences for shrouding clothes:
The Funeral Director I would prefer: Mobile:
I would like to have my Funeral Mass/Service at:
The Priests/Pastors/Celebrants I would like to have at my Funeral are:
Hymns/Songs I would like to have at my Funeral are:
I would like to be buried at:
I would like to be cremated:
My Notary/Lawyer is: Mobile:

L. Any special message you wish to write:

Eg. Leaving a message to your family or someone close to you? What happens to your pets? What do you want to happen to some objects of sentimental value that you have etc.

M. Signatures (The Person's and the Relative's/Other Witness)*

	Name and Surname	Signature
Person		
Relative/Other Witness		

N. Multidisciplinary Team's Signatures*

	Name and Surname	Signature
Senior Caring Doctor		
Nurse		
Occupational Therapist		
Physiotherapist		
Social Worker		
Speech Language Pathologist		

NOTE: The Multidisciplinary Team signing this document declares that their primary role in the filling of this Advance Care Plan was to assist the Person to express his/her wishes and preferences for their end-of-life care. The Team appreciates that the Person was able to understand that an Advance Care Plan is not legally binding, and also was aware that it could affect future decisions on matters that might affect their life (see Section D1 and D2).*

NOTE to DOCTORS AND OTHER HEALTH PROFESSIONALS: In situations where Doctors and/or other Health Professionals hold sound reservations to be involved in filling out this Advance Care Plan, they should inform their Patient/Client about their decision, so that the Person would then seek alternative support from other sources.*

_____ Authenticated copies where signed today _____

(*Here write number of copies*) (Date: DD/MM/YYYY)

Indicate below who has an authenticated copy:
(Ideally, a copy should also be kept in the Patient's File)

_____

_____

_____

_____

_____

O. Updates to the Advance Care Plan Document

Kindly note any changes to the Advance Care Plan Document below.

Update 1

Date:

_____ _____

Person's/Relative's Signature Witness' Signature

_____

Senior Caring Doctor's Signature* *(see note on page 8)*

Update 2

Date:

_____ _____

Person's/Relative's Signature Witness' Signature

_____

Senior Caring Doctor's Signature* *(see note on page 8)*

Update 3

Date:

_____ _____

Person's/Relative's Signature Witness' Signature

_____

Senior Caring Doctor's Signature* *(see note on page 8)*

Additional Comments:

GERIATRIC MEDICINE
SOCIETY OF MALTA
Promoting excellence in the
care of older adults

This document is free to use and has been drawn up for the Maltese Population by the Advance Care Planning Working Group, Geriatric Medicine Society of Malta. December 2023.