My name:	Date of Birth:
Address:	Telephone number • Home: • Mobile:

My Advance Statement (v2011.07.06)

Calderdale and Huddersfield NHS Foundation Trust

This document should be read by professionals who care for me, and need to know my views on my future care.

If I am unable to be involved in decisions about my care, this Advance Care Plan may help you make a decision in my best interests.

I can change my mind about my wishes at any time. This document is not legally binding.

If I cannot communicate easily,

- **you can help me by:**
- **if a decision needs to be made, please talk to:**
- **please keep the following people informed of my progress:**

Information that I need from the people looking after me:

Things that are important to me:

I am concerned / worried about:

Things I would like to happen to me:

When time is short, I would like:

At the very end of my life, <u>if circumstances allowed</u>, my first choice for my place of care would be : (circle first choice)

Home
Hospice
Hospital

- **This is because:**
- **<u>If this care was not available, my second choice would be</u>:**

Religious / spiritual things important to me:

My name:	Date of Birth:
Address:	Telephone number • Home: • Mobile:

The list below shows who has been given / sent a copy of my advance care plan

Name	Relationship	Telephone Number

An Advance Decision to Refuse Treatment is a more legally binding statement of a person's wishes about future care. I wish to complete one of these: YES ☐ NO ☐

This advance care plan replaces any earlier statements of this kind.

Patient's signature: …… **Date**: ……

For professional use only:

Professional who has helped the patient complete this form:

Name…… Role…… Contact no. …… Date ……..

- Was the patient offered an opportunity to complete ACP ?
  - No ☐ – state reason ACP not offered:……
  - Yes ☐ – did the patient complete the ACP?
    - Yes ☐
    - No ☐