My Advance Care Plan (Please Complete in English)

내의 advance care plan (영어로 작성)

Last name: ______________________________ Date of birth __/__/____
First name: ______________________________

My Advance Care Plan is a record of your advance care planning discussion and a way of informing those who are caring for you of your preferences. Your preferences may not necessarily be health related but will guide your treating health professionals, Enduring Guardian and or family as to how you wish to be treated including any special requests or messages.

Please note: Should you wish to make legally binding treatment decisions, it is recommended that you record these decisions in an Advance Health Directive. You may also wish to give consideration to appointing an Enduring Guardian to make personal, lifestyle and treatment decisions on your behalf. See the Guide for further detail.

I have given a copy of my Advance Care Plan to:

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<tr>
<th>Full name</th>
<th>Telephone</th>
<th>Mobile</th>
<th>Relationship to me</th>
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Health.wa.gov.au

My Advance Care Plan – Arabic

خطة رعايتي المسبقة (يرجى استكمال النموذج باللغة الإنجليزية)

Last name: ______________________________ Date of birth __/__/____
First name: ______________________________

خطة رعايتي المسبقة هي سجل المناقشة المتعلقة بتخطيطك المسبق لرعايةك وطريقة لإخبار أولئك الذين يهتمون بك عن رغباتك. قد لا تكون رغباتك بالضرورة ذات صلة بالصحة، لكنها ستوجه المحترفين الصحيين الذين يعالجونك، والوصي الدائم و/أو الأسرة إلى رغباتك المتعلقة بكيفية علاجك بما في ذلك أية طلبات خاصة أو رسائل.

الرجاء الانتباه: إذا كنت ترغب في اتخاذ قرارات العلاج الملزمة قانونًا، فمن المستحسن أن تقوم بتسجيل هذه القرارات في الطلب الخاص بالرعاية المسبقة. قد ترغب أيضًا في الاعتبار تعيين وصي دائم يتخذ القرارات الشخصية والمتعلقة بنمط حياتك وعلاجك.

لقد أعطيت نسخة من خطة رعايتي المسبقة إلى:

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<th>Full name</th>
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I have completed one or more of the following:

**Advance Health Directive**

التوجيه الصحي المسبق

Yes/No (please circle)

I have stored a copy at: ________________________________

A copy can also be obtained from:

Name: _____________________________________________

Telephone: _______________________________________

**Enduring Power of Guardianship**

السلطة الدائمة للوصاية

Yes/No (please circle)

I have stored a copy at: ________________________________

A copy can also be obtained from:

Name: _____________________________________________

Telephone: _______________________________________

**Enduring Power of Attorney**

وكالة دائمة

Yes/No (please circle)

I have stored a copy at: ________________________________

A copy can also be obtained from:

Name: _____________________________________________

Telephone: _______________________________________

**Will**

وصية

Yes/No (please circle)

I have stored a copy at: ________________________________

A copy can also be obtained from:

Name: _____________________________________________

Telephone: _______________________________________
Preferences for my future care
These are my preferences, in relation to my future care.
Please refer to the Advance Care Planning Guide for Patients.

رغباتي لرعايتي المستقبلية
هذه هي رغباتي، فيما يتعلق برعايتي في المستقبل.
يرجى الرجوع إلى دليل المرضى للتخطيط المسبق للرعاية.

Other outcomes of the Advance Care Planning conversation:
For example, you may have considered completing other relevant legal documents such as an Advance Health Directive or Enduring Power of Guardianship or you may have decided to become an organ donor.

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<th>Outcome</th>
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If I have lost capacity or am approaching end of life, where practical and appropriate, I would prefer to be cared for:

Initial the option you prefer:

- [ ] In my usual home:

- [ ] At a family member’s home:

- [ ] At a hospice or palliative care unit

- [ ] In hospital

- [ ] On country (for Aboriginal and Torres Strait Islanders)

- [ ] At another place:

I would like to leave the following message(s)

For example: I am a carer for my partner/family member or I would like the following person to care for my pet, or I would like a particular song played or I would like a particular complementary therapy to be used or I would like my family to respect my preferences to be an organ donor etc.

Signed: ____________________________ Date: _____ / _____ / _____

This document can be made available in alternative formats on request for a person with disability.

Produced by WA Cancer and Palliative Care Network
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