DementiaUK
Helping families face dementia

My Advance Care Plan

My details:

My Name:	
Date of Birth:	
Address:	
Postcode:	
Telephone:	
Mobile:	

Name of Proxy/Next of Kin 1:	
Name of Proxy/Next of Kin 2:	

Please add your details to page 7

My Advance Statement

My decisions:

If you are no longer able to care for yourself, where would you prefer to be cared for if possible?

Preferred Place of Care 1:	
Preferred Place of Care 2:	
Special requests and preferences for your care:	

Where would you prefer to die?

1st Preference:

2nd Preference:

Do you have a Living Will or an Advance Decision to Refuse Treatment (ADRT)? ☐ Yes ☐ No

If yes, please give details (e.g. who has a copy):

Do you have a Will? ☐ Yes ☐ No

If yes, where is it held:

Would you like to discuss how to make a Will? ☐ Yes ☐ No
(Please go to page 5 of your Planning Now and for your Future guide to find out more about how to make a Will.)

What are your thoughts and wishes about organ donation?

Things that are important in my life now

The most important people in my life now are (e.g. wife/husband/partner/friend):
(You may wish to discuss why these people are important)

1.

2.

3.

Please use the notes section on page 12 if you have more to add

Who or what supports you when things are difficult?

Do you have a particular faith or set of beliefs that are important to you?
(For example: a religious belief, as this may help to determine the type of ceremony or spiritual support you may want to have at End of Life)

Is there anyone who can help you to uphold these faith or beliefs? ☐ Yes ☐ No

If yes, please name them here:

What activities do you enjoy most in your life now?
Explain why they are important to you and whether you would like help to continue if you are unable to do this for yourself in the future.

1.

2.

3.

Please use the notes section on page 12 if you have more to add

Is there anything else in your life that is important to you now?
Explain why it is important and if there is anyone who can help you with it.

1.

2.

3.

Please use the notes section on page 12 if you have more to add

Does anyone have Lasting Power of Attorney (LPA) for you for:

Property and Financial Affairs: ☐ Yes ☐ No

Health and Welfare: ☐ Yes ☐ No

If yes, please fill out their details below

Attorney LPA: (Property and Financial Affairs):

Telephone:

Mobile:

Email:

Address:

Postcode:

Attorney LPA: (Health and Welfare):

Telephone:

Mobile:

Email:

Address:

Postcode:

If you don't have an LPA, would you like to discuss how to make one? ☐ Yes ☐ No

My funeral arrangements

I want to be: ☐ Buried ☐ Cremated ☐ Other (Tick as appropriate)

If you have ticked other, please give more information here:

If cremated, I would like my ashes to be (for example, scattered, placed with those of another):

My preferred funeral director is:
or
My funeral arrangements are already made with:

I wish my funeral to be in accordance with my faith and beliefs. State if any:

I would like the service to be at:

I would like the following music, hymns, readings etc:

I would like: (Name) _____ to conduct the service (if possible)

I would like: (Name) _____ to do the reading (if possible)

I would like flowers: ☐ Yes ☐ No

I would like donations (if any) made to:

Any additional comments from those close to you: (Please include their name)

Signatures

Own signature:

Admiral Nurse:

Date:

Date:

Others involved in drawing up this plan

Name:

Signature:

Date:

Name:

Signature:

Date:

Name:

Signature:

Date:

Name:

Signature:

Date:

Are you happy for the information in this document to be shared with relevant healthcare professionals? ☐ Yes ☐ No

Important Contacts

We recommend sharing this Plan with all of your important contacts

Name of Proxy/Next of Kin

Name:

Telephone: Mobile:

Email:

Address:

Postcode:

Name of Proxy/Next of Kin

Name:

Telephone: Mobile:

Email:

Address:

Postcode:

Person who knows me well[1]

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

Person who knows me well[2]

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

Admiral Nurse

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

GP

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

Other (e.g. District Nurse, Social Worker)

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

Other[1]

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

Other[2]

Name:

Telephone: Mobile:

Out of hours:

Email:

Address:

Postcode:

Reviews of My ACP

This plan should be reviewed regularly to ensure that it represents your wishes and preferences. We suggest every three to six months. Sign and date any changes made to record each review.

Review date:

Signed:

Date:

Any changes made? ☐ Yes ☐ No

If YES, add details:

Review date:

Signed:

Date:

Any changes made? ☐ Yes ☐ No

If YES, add details:

Review date:

Signed:

Date:

Any changes made? ☐ Yes ☐ No

If YES, add details:

Review date:

Signed:

Date:

Any changes made? ☐ Yes ☐ No

If YES, add details:

Review date:

Signed:

Date:

Any changes made? ☐ Yes ☐ No

If YES, add details:

Review date:

Signed:

Date:

Any changes made? ☐ Yes ☐ No

If YES, add details:

Add more review dates as required.

Notes