Living Matters
advance care planning

Advance Care Plan (ACP) – General

Instructions to the healthcare team:	**Patient's Particulars**	
This ACP reflects the preferences of the patient and/or the Nominated Healthcare Spokesperson (NHS) for the patient. This is useful in times of emergency or when the patient loses mental capacity or patient is a minor. The attending doctor and primary care team should always act in the best interests of the patient. The ACP should be reviewed with the patient and NHS/family if there is a change in the health status of the patient. This includes having a Preferred Plan of Care (PPC) discussion should the patient become seriously ill.	***Name:** **(as per NRIC)**	
	***NRIC / ID No**:	
	***Citizenship:** *(Pink/Blue IC, Work Pass or Others)*	
	***Gender:**	
	***Date of Birth:**	
	***Home Address:**	
	***Institution/ Programme Name:**	
	Place of Documentation:	
	***Date of Session:**	

1. My understanding of my current health and any concerns:
   (Explore my current health, including any health concerns and if I had experience with family or friends who became seriously ill.)

2. The following activities are important for me to live well, as they give my life meaning. Please consider these values when making healthcare decisions on my behalf if I lose mental capacity (the ability to make my own decisions) in the future.

   **2A. Activities that bring joy and meaning to my life include:*
   (Some examples are being independent in my daily life, spending quality time with family and friends, enjoying my hobbies etc.)

   2B. What helps me when I face serious challenges in life?

   2C. Fears or worries I have about my illness or medical care.

   **2D. The following elements of care are important to me:*

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3. *If I have an injury or illness, and my doctors believe that further aggressive treatment will not reverse my medical condition and that I will have a low chance of recovering the ability to make decisions for myself and I would not know who I am, who I am with or where I am, I would prefer the following goal of medical care.

☐ Make comfort the goal of my care, such as providing me with medication to help with my breathing to make me comfortable. Do not prolong my life in this condition. How I live my life means more to me than how long I live. Other comments:

☐ Continue to receive all necessary life-sustaining treatment such as a breathing support machine until the outcomes (as stated in the comments below) happen to me which I find unacceptable. These measures are subject to the assessment and decisions of the care team. Other comments:

☐ I am not ready to decide at this point. Other comments:

4. Other special requests, preferences or comments:
(For example, any other religious, cultural, or personal beliefs that might influence my preferences for my treatment choices?)

Consent by Patient and/or Nominated Healthcare Spokesperson(s) ("NHS"):

(1) ACP is done with Patient and/or NHS and aligns with Patient's known desires and best interest.

(2) Personal Data Protection Act (PDPA)

I consent to my personal information being collected by, shared between, disclosed to, and/or used by:

(i) the Ministry of Health ("MOH");
(ii) the Agency for Integrated Care Pte Ltd ("AIC");
(iii) any government agency or government-related entity approved by MOH; and
(iv) any healthcare provider involved in or assisting with my care;

For the purposes of:

(a) facilitating the patient's care;
(b) facilitating the administration, monitoring and improvement of healthcare-related programmes, schemes, or services;
(c) improving the quality of public healthcare services;
(d) developing and reviewing public policies; and/or
(e) any other purposes reasonably related to the above purposes.

*__Patient's Name__ (as per NRIC): *Contact No: Email Address: *Signature: *Date of Signing:	*__Primary NHS's Name__ (as per NRIC): *Relationship: *Contact No: Email Address: *Signature: *Date of Signing:	*__Secondary NHS's Name__ (as per NRIC): *Relationship: *Contact No: Email Address: *Signature: *Date of Signing:

*__Facilitator's Name__ (as per NRIC): *Last 4 characters of NRIC: *Institutions: *Signature: *Date of Signing: **Declaration by Facilitator:** *If no Patient and/or NHS signature(s)* ☐ I declare: (i) ACP is done with Patient and/or NHS and aligns with Patient's known desires and best interest. (ii) Patient and/or NHS have been informed of, and have consented to, the collection, use and/or disclosure of their personal data for purposes stated in the PDPA section of this form.	**Contact Details of ACP Office** For changes to care preferences or Nominated Healthcare Spokesperson's information, please contact the ACP office at the following phone number(s) during office hours. Phone No: