Fy Mywyd, Fy Nymuniadau
My Life, My Wishes

My Life
My Wishes

This is MY document

GIG CYMRU NHS WALES
Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Welcome to My Life, My Wishes

This document is an Advance Care Plan (ACP) or Statement of Wishes. It has been designed for use by adults who have mental capacity (the ability to make their own decisions). Completing it is a voluntary process that can help you record your wishes about how you would like to be cared for in the future.

This information can be very helpful for your loved ones and for health care professionals involved in your care and treatment. You do not need to be unwell to complete it. This is your document – health care professionals may take copies if you wish, but this document needs to stay with you. If you are happy to share this document with your health care professionals, please make sure you read the information on page 11.

You can complete this document by yourself, with a person close to you or with a healthcare professional. It can be changed at any time and is **not a legally binding document**. You do not need to complete the whole document and can revisit any section if required. It is a good idea to review your wishes regularly and let your health care professionals know of any updates that you make. Please sign and date any additions or changes (as well as signing and dating on page 11 on first completing your ACP).

The information in this document will only be considered if you cannot communicate your wishes. It will be helpful if those close to you know about this document, and where it is kept.

If you need help to complete this document see the My Life, My Wishes Guidance booklet, or contact your GP surgery, local ACP champion or any health care professional involved in your care.

For further information and advice see *www.powysthb.wales.nhs.uk/mylifemywishes*

Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

Section 1

Name:.....Date of Birth: .....

Address: .....

.....

Post Code:.....Email: .....

Telephone:.....Mobile: .....

People Helping Me to Complete this Document:

Name: .....Relationship to me:.....

Name: .....Relationship to me:.....

People Important to Me:

Name:	Relationship:	Contact number:	Other info (e.g. emergency contact, next of kin, main carer, attorney.)

Health and Social Care Professionals Involved in my Care:

Name:	Role:	Contact number:

Section 2 - Thinking Ahead

My Values and Beliefs – These are the things that are most important to me

(for example, my view on life, my religious/spiritual beliefs, my preferred language and the name I like to be called)

My Health - What has been happening to me

(for example, details of any illnesses and treatments, and my understanding of the future)

Section 3 - My Future

Specific Wishes - My wishes and priorities for my future care

(For example, where and how I would like to be cared for)

Specific Wishes - What I do NOT want to happen to me

(for example, what I worry about or fear happening to me)

If you have clear wishes about treatments or interventions that you would not want, please discuss these with your Doctor or Healthcare Professional. They can help you to formalise these wishes by completing a legally binding Advance Decision to Refuse Treatment (ADRT) or other documentation.

Section 4 - My Last Days

What is most important to me in the last days of my life

(For example, who I would want with me when I am nearing the end of my life, any religious or spiritual practices that I would like, music that I would like to hear)

Where I would prefer to be cared for at the end of my life:

First Preference:.....

.....

Second Preference:.....

.....

Section 5 - After my death

I have made a Will: (please circle) **Yes** **No**

If yes, My Will is kept:

.....

.....

My wishes about organ and tissue donation are:

.....

.....

(Please discuss your wishes with people who are important to you and your Health Care Professional. If you do not want to become an organ or tissue donor, you must register to 'opt-out' by contacting Organ Donation Wales.)

My wishes regarding burial or cremation:

.....

.....

What I want for my funeral (including details of any plans/policies held):

.....

.....

.....

.....

.....

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.....

Section 5 - After my death

What to do with my Internet accounts

(For example, who I would like to manage my social media accounts and on line bank accounts)

.....

.....

.....

Details of my responsibilities, and the arrangements that I have made for them

(For example, dependant family members or pets):

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.....

.....

Additional Information

Please use this space for updates, changes to your plan or anything you wish to add. Please sign and date changes or additions on page 11

Section 6 - Information for Health Care Professionals

Cardiopulmonary Resuscitation (CPR)

(Has this been discussed with you? What are your thoughts regarding CPR?)

.....

.....

Do you have a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) document in place? (Please circle)**: YES NO**

If "Yes" where is it kept?

.....

.....

Do you have any allergies?

.....

.....

Communicating my wishes:

If you lose capacity to make your own decisions, or cannot communicate your wishes, is there anyone you would like to have consulted about your care?

.....

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.....

.....

Do you have a Lasting Power of Attorney (LPA) for Health and Welfare?

Yes No

Do you have a Lasting Power of Attorney (LPA) for Legal and Financial matters?

Yes No

If you do have a Lasting Power of Attorney (LPA), please include the Attorney's details in Section 1, People Important to Me, on page 3.

My Other Documents:

(You can keep your other documents in your folder, otherwise please state location)

Document	(if available, please tick box)	Date and location
DNACPR (Do not attempt cardio-pulmonary resuscitation)	☐	.....
		.....
Lasting Power of Attorney	☐	.....
		.....
Advance Decision to Refuse Treatment	☐	.....
		.....
'This is me'/Hospital Passport (used in hospitals and care homes)	☐	.....
		.....
Repeat Prescription	☐	.....
		.....
Any other documents:		
.....	☐	.....
.....	☐	.....
.....	☐	.....

If you would like help to complete any of these documents or to discuss them further, please ask your Health Care Professional.

Please sign and date on completion:

Signed: ..... Date: .....

If you choose to share this document with a health care professional, we may need to share some of this information about you so that everyone involved in your treatment or care can work together for your benefit. This could be NHS organisations, social services or private and voluntary healthcare providers.

Further information on how your personal information is used can be found at: *www.powysthb.wales.nhs.uk/sitesplus/documents/1145/Your%20Information%20Your%20Rights%20A4Leaflet.pdf*

Please sign and date whenever you update your plan

Signed: ..... Date: .....

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