

An ONTARIO ADVANCE CARE PLAN for HEALTH CARE
Study # _____

Identification

Name: _____ Alias, if any: _____

Mailing address:

Phone: _____ Email: _____

Birth date (Day, Month, and Year): _____

Religion: _____

Name and contact information for family members you would want notified if you were seriously ill or dying.

People/agencies that should be notified in case of serious illness, injury or death:

Things which would help emergency and health care staff to identify me, i.e. scars, tattoos, body piercing, birthmarks, photo, or other identification (describe and provide its location):

MY RIGHT TO MAKE HEALTH DECISIONS

I understand that

- Health decisions are decisions about treatment or about moving into a long term care home.
- I have the right to agree to (consent) or not agree to (not consent) to any health care that may be offered to me or that I may need.
- I have the right to make all decisions about health care for myself unless a health practitioner determines that I am not mentally capable to make a particular decision or it is an emergency and the health practitioner needs to treat me without consent to save my life or save me from serious harm to my health
- If I am not mentally capable, I understand that another person – my Substitute Decision Maker – would be asked to make health care decisions for me.
- I understand that I have an AUTOMATIC Substitute Decision Maker (see section 1- Part A on page 4).
- I also understand that I can CHOOSE someone to be my Substitute Decision Maker by signing the part of this document that is a Power of Attorney for Personal Care. That Substitute Decision Maker is called an “Attorney for Personal Care” (see Part 1 section B on page 8).
- If the health practitioner believes that I am not mentally capable to make a particular health decision for myself, then, before asking my Substitute Decision Maker to make any decision for me, the health practitioner, except in an emergency, is required to tell me that:
 - ✓ he or she has found me mentally incapable to make that health decision for myself ;
 - ✓ the health practitioner will ask my Substitute Decision Maker to make health decisions for me
 - ✓ I have the right to ask for a review of that finding of incapacity by applying to the Consent and Capacity Board, a type of tribunal, for a hearing
- I am entitled to be represented by a lawyer before the Consent and Capacity Board. I may be eligible to get legal assistance paid for by Legal Aid if I meet their financial criteria. If not, I can hire my own lawyer. I can also represent myself. There is no charge to challenge a finding of incapacity at the Consent and Capacity Board.
- I may be eligible to get legal assistance from Legal Aid to do that review or I can represent myself. There is no charge to challenge that finding of incapacity at the Consent and Capacity Board.
- I may decide NOT to apply to the Consent and Capacity Board to review the finding of incapacity and instead let my Substitute Decision Maker make decisions for me.
- If I do apply for a review and the Consent and Capacity Board finds me mentally capable, then the health practitioner must let me make decisions for myself.

- If the Board confirms that I am incapable then the health practitioner will ask my Substitute Decision Maker to make the health decisions for me.

THIS DOCUMENT

I _____, understand this document allows me to do
(Full name)

one or both of the following:

Part 1 - Confirm who is my Automatic Substitute Decision Maker or Appoint a Substitute Decision Maker of my own Choice (an Attorney for Personal Care) to make ONLY HEALTH decisions to which the Ontario *Health Care Consent Act, 1996* applies for me if I am not mentally capable to make these health decisions for myself:

Part 2 – Communicate my Wishes about my future health care to guide my Substitute Decision Maker, whether that person is my Automatic Substitute Decision Maker or a Substitute Decision Maker of my own choice (an Attorney for Personal Care) when making decisions for me. These wishes are also intended to guide my health practitioners in an emergency

Part I

AUTOMATIC SUBSTITUTE DECISION MAKER OR CHOICE OF SUBSTITUTE DECISION MAKER

- I understand that I already have a Substitute Decision Maker even if I don't sign this document because the *Health Care Consent Act* (the law) provides for that. The person who is my automatic Substitute Decision Maker is explained below.
- If I don't want that person who is my automatic Substitute Decision Maker to make decisions for me when I am incapable, then I have the right, while capable, to CHOOSE someone (or more than one person) to be my Substitute Decision Maker to act for me in the place of my automatic Substitute Decision Maker .
- If I want to choose someone to act as my Substitute Decision Maker, then I must sign a Power of Attorney for Personal Care. I cannot choose someone by just saying that I want them to act as my Substitute Decision Maker. This can ONLY be done in writing in a Power of Attorney for Personal Care.
- A Power of Attorney for Personal Care gives NO authority to my chosen Substitute Decision Maker to manage or access any of my money or property.
- If I name someone to be my Substitute Decision Maker by signing THIS document, and it is properly witnessed, this document would be a Power of Attorney for Personal Care and would be limited to giving authority to my Substitute Decision Maker to only make health decisions to which the Ontario *Health Care Consent Act, 1996* applies for me if I am found incapable of making those decisions.
- The Power of Attorney for Personal Care is explained below at Page 8.

Part 1 - Section A

AUTOMATIC SUBSTITUTE DECISION MAKER BY LAW

I understand that I have an automatic Substitute Decision Maker if a health practitioner determines that I am not mentally capable to make a particular health decision to which the Ontario *Health Care Consent Act, 1996* applies.

The *Health Care Consent Act* (the law) states that if I have any of the following people in my life

1. **My Spouse or Partner**
2. **My Child or parent**
3. **My Brother or sister**
4. **Any of my other relatives**
5. **Public Guardian and Trustee**

that are:

- a) available (can be contacted);
- b) are him or herself mentally capable to make health decisions;
- c) willing to act as my Substitute Decision Maker and make decisions for me; and,
- d) are not otherwise prohibited by a court or tribunal order as acting as my Substitute Decision Maker,

then that person or persons would be my Substitute Decision Maker unless one of the following conditions is met:

- there is no Court Order naming someone to be my **Guardian for Personal Care**. To be your Guardian for Personal care , someone would have apply to the Superior Court, prove that you are mentally incapable to make personal care decisions for yourself, and then be authorized by the court to make decisions for you. Few people have Court Ordered Guardians for Personal Care but if you do have one, you cannot sign a Power of Attorney for Personal Care. To remove your Guardian you would need to get legal advice and go to Court.
- I have not already chosen my own **Attorney for Personal Care** by signing a Power of Attorney for Personal Care. Part 1- Section B of this document, if properly completed, is a Power of Attorney for Personal Care
- the Consent and Capacity Board has not appointed anyone to be my “Representative” A **Representative** is appointed by the Consent and Capacity Board to act for you, after you become incapable. You or someone who wants to make decisions for you would have to apply to that tribunal to have that person named to make decisions for you. If someone applies to the tribunal to be named as your Representative, the person applying to be appointed is required to notify you of the hearing and that you have the right to challenge that appointment.

WHO ARE THE AUTOMATIC SUBSTITUTE DECISION MAKERS?

DEFINITIONS:

Spouse or Partner

Two persons (either same sex or opposite sex) are “spouses” if they are:

- a) married to each other; or
- b) are living together in a common law (not married) relationship
 - for at least one year or
 - are the parents of a child together, or
 - have entered into a “cohabitation agreement” under the *Family Law Act*.

Two persons are not spouses if they are living separate and apart as a result of a breakdown of their relationship.

Two people are “partners” if they have lived together for at least one year and have a close personal relationship **that is of primary importance in both people’s lives**. This can include friends who have lived together for at least one year in a non-sexual relationship and have a special personal family-like relationship.

Child or Parent

A “child” is a child that was born to you or that you adopted or that you treated as your child and supported over a period of time. Your child must be at least 16 years of age to act as your Substitute Decision Maker. If you have more than one child all of them are your Substitute Decision Makers (as long as they meet the other requirements) or they can decide amongst themselves which of them (can be more than one) will act as your Substitute Decision Maker.

Your parent can be your Substitute Decision Maker even if your parent is of advanced age as long as he or she is mentally capable, available and willing to act as your Substitute Decision Maker. A parent who is under the age of 16 can be the Substitute Decision Maker for their child as long as they meet these requirements.

Brother or Sister

If you have more than one brother or sister, all of them are entitled to act as your Substitute Decision Maker if they meet the requirements. They can decide amongst themselves which of them or how many of them will act as your Substitute Decision Maker.

Any other Relative

People are relatives if they are related by blood, marriage or adoption.

Public Guardian and Trustee

The Public Guardian and Trustee is a government office that will become your Substitute Decision Maker if you have not signed a Power of Attorney for Personal Care or if none of your Automatic Substitute Decision Makers are mentally capable, willing, or available to act as your Substitute Decision Maker or if there is no court order or tribunal order appointing someone to be act as your Guardian or Representative. The Public Guardian and Trustee will also act as your Substitute Decision Maker if there is a disagreement between your Substitute Decision Makers who are entitled to make decisions for you. For example, if you have four brothers who are your Automatic Substitute Decision Makers and they can’t agree on health decisions for you, even if it’s three against one, then the health practitioner must ask the Public Guardian and Trustee to make the decision for you. .

HOW MY AUTOMATIC SUBSTITUTE DECISION MAKER IS REQUIRED TO MAKE DECISIONS FOR ME

My Automatic Substitute Decision Maker(s), whomever he or she or they are, is required to make health decisions to which the Ontario *Health Care Consent Act, 1996* applies for me based on my wishes, whether these wishes are put in writing or told by me orally or communicated by me in any way I am able to communicate including if I use an assistive device.

If my Automatic Substitute Decision Maker doesn't know of my wishes that are relevant to making a particular decision for me, then I understand that my Automatic Substitute Decision Maker is required to make decisions for me that are in my best interests.

These same decision-making rules apply to Substitute Decision Makers I choose for myself by signing a Power of Attorney for Personal Care.

The *Health Care Consent Act* sets out the rules for making treatment decisions, decisions about going into a long-term care home, and personal assistance services in a long-term care home where the Substitute Decision Maker is acting in the best interest of the person. For example, for treatment decisions, the rules are as follows:

1. If the person knows of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, the person shall give or refuse consent in accordance with the wish.
2. If the person does not know of a wish applicable to the circumstances that the incapable person expressed while capable and after attaining 16 years of age, or if it is impossible to comply with the wish, the person shall act in the incapable person's best interests.

Best Interests

In deciding what the incapable person's best interests are, the person who gives or refuses consent on his or her behalf shall take into consideration,

- (a) the values and beliefs that the person knows the incapable person held when capable and believes he or she would still act on if capable;
- (b) any wishes expressed by the incapable person with respect to the treatment that are not required to be followed under paragraph 1 of subsection (1); and
- (c) the following factors:
 1. Whether the treatment is likely to,
 - i. improve the incapable person's condition or well-being,
 - ii. prevent the incapable person's condition or well-being from deteriorating, or

- iii. reduce the extent to which, or the rate at which, the incapable person's condition or well-being is likely to deteriorate.
- 2. Whether the incapable person's condition or well-being is likely to improve, remain the same or deteriorate without the treatment.
- 3. Whether the benefit the incapable person is expected to obtain from the treatment outweighs the risk of harm to him or her.
- 4. Whether a less restrictive or less intrusive treatment would be as beneficial as the treatment that is proposed.

Before giving or refusing consent to treatment on my behalf, my Substitute Decision Maker is entitled to receive all information required to make an informed consent, including the nature of the treatment; expected benefits, material risks and material side effects of the treatment; alternative courses of action; the likely consequences of not having the treatment, and have any other questions answered.

I understand that I should talk to my Substitute Decision Maker to make sure that he or she or they are willing to act as my Substitute Decision Maker, will likely be available if I need any health decisions made for me, and that they know my wishes about my health care to guide them when acting as my Substitute Decision Maker for health care.

CONFIRMATION OF AUTOMATIC SDM (complete if you want your automatic SDMs to be your SDMs and you don't want to make a Power of Attorney for Personal Care)

Date: _____

I _____, confirm that the following person or persons are my automatic SDMs and I want them to be my SDMs.

Name:
 Relationship to me:
 Address:
 Telephone:
 Email:

Name
 Relationship to Me
 Address:
 Telephone:
 Email:

I confirm that I do NOT want to choose another SDM and do NOT want to sign a Power of Attorney for Personal Care. (Proceed directly to Part 2 on Page XX)

 Witness

 Person Signing)

Part 1 - Section B

APPOINTING A SUBSTITUTE DECISION MAKER – POWER OF ATTORNEY FOR PERSONAL CARE LIMITED TO HEALTH CARE DECISIONS to which the Ontario *Health Care Consent Act, 1996* applies

(If you want to have your Automatic Substitute Decision Maker act as your health decision maker go to Part 1- Section A on page 4 above and skip this section)

- I understand that I can CHOOSE someone or more than one person to be my Substitute Decision Maker (s) by signing a Power of Attorney for Personal Care.
- **The Substitute Decision Maker I choose by signing a Power of Attorney for Personal Care is called my “Attorney for Personal Care”.**
- This document is a Power of Attorney for Personal Care that is limited to health care decision making to which the Ontario *Health Care Consent Act, 1996* applies, if properly signed and witnessed. Health care decisions include decision about treatment, about admission into a long term care home, and about personal assistance services in a long term care home.
- If I choose someone by signing this document then my Automatic Substitute Decision Maker will not be able to make health decisions for me unless my chosen Substitute Decision Maker (my attorney) becomes incapable, or is unwilling to act or is not available.

WHO CAN I CHOOSE TO BE MY ATTORNEY FOR PERSONAL CARE?

- I can choose ONE person or MORE than one person to act as my Attorney for Personal Care.
- I understand that I cannot choose as my Attorney for Personal Care anyone that provides me with health care, such as a health practitioner or health service provider OR provides me with residential, social, training or support services and gets an income for doing that work unless that person is my spouse, partner or relative (see definitions of “spouse, partner and relative on Page 5)
- If I choose MORE than one person I can state that they must always make decisions TOGETHER (JOINTLY) or that they can make decisions TOGETHER OR SEPARATELY (Joint and Separately) so if only one of them is available, that person can make decisions for me alone) or together if they are both available.
- Whoever I choose should be someone that I TRUST that will make health decisions for me based on my wishes, whether these wishes are put in writing or told by me orally or communicated by me in any way I use to communicate if I use an assistive device.

- If my Attorney for Personal Care doesn't know of my wishes that are relevant to making a particular decision for me then I understand that my Attorney for Personal Care is required to make decisions for me that are in my best interests.
- I understand that I should talk to my Attorney for Personal Care to make sure that he or she or they are willing to act as my Attorney for Personal Care, will likely be available if I need an Substitute Decision Maker, and that they know my wishes about my health care to guide them when acting as my Substitute Decision Maker.

DECISIONS MY ATTORNEY FOR PERSONAL CARE CAN MAKE FOR ME - LIMITED POWER OF ATTORNEY FOR PERSONAL CARE

- I understand that a Power of attorney for Personal care that is NOT limited to health care would give my Attorney for Personal Care authority to make all decisions about "personal care" for me if I became mentally incapable. These include all decisions about shelter (where I live), food, hygiene, clothing, safety, AND health care.
- **THIS document is a LIMITED Power of Attorney for Personal Care.**
- By signing this document below and choosing an Attorney for Personal Care , I understand that I am signing a Limited Power of Attorney for Personal Care that gives authority to my Attorney for Personal Care to ONLY make decisions for me about health care to which the Ontario *Health Care Consent Act, 1996* applies. Health care decisions include decisions about any treatments as well as decisions about admission into a long term care home if I need that type of care.
- **My Attorney for Personal Care in this Limited Power of Attorney for Personal Care will have NO authority to manage my money or access my income.**

POWER OF ATTORNEY FOR PERSONAL CARE

I _____ make this this Power of Attorney for Personal Care to name an Attorney for Personal Care with authority limited to make for me decisions to which the Ontario *Health Care Consent Act, 1996* applies.. Decision to which the Health care Consent Act 1996 applies include decision about treatment, about admission into a long term care home, and about [personal assistance services in a long term care home.

This Attorney for Personal Care will have no authority to make any other personal care decisions for me other than health care decisions to which the Ontario *Health Care Consent Act, 1996* applies and no authority to make any decisions about or have access to my money or income or personal property.

I APPOINT :

Name:
Relationship to me:
Address:
Telephone:
Email:

(If you want more than one person to be your Substitute Decision Maker, add the additional name below)

Name:
Relationship:
Address:
Telephone:
Email:

to be my **Attorney for Personal Care** limited to make for me decisions to which the Ontario *Health Care Consent Act, 1996* applies..

If I have named more than one Attorney for Personal Care, I want them to make decisions

- SEPARATELY (if only one of the two Attorneys for Personal Care is available he or she will make decisions for me even if the other is not available)
or
- JOINTLY (both Attorneys for Personal Care must agree and make all decisions together)
or
- I want them to be able to act BOTH JOINTLY and SEPARATELY (i.e. if one Attorney for Personal Care is available and the other is not, then whoever is available will make decisions but if BOTH are available they both would have the right to make decisions together)

Grantor and Witnesses Initials _____

CONDITIONS AND SPECIFIC INSTRUCTIONS

I authorize my Attorney for Personal Care to ONLY make decisions to which the Ontario *Health Care Consent Act, 1996* applies, taking into consideration my wishes or any specific instructions about my future health care whether I have written these down or communicated these orally or communicated these by any other means that are relevant to the health care decisions my Attorney for Personal Care is required to make on my behalf.

Wishes and instructions are relevant if:

- I was mentally capable at the time I wrote them down or communicated them
- If I changed them and I was mentally capable at the time I changed them, then the wishes or instructions that were last communicated are the ones that should be followed, no matter how I communicated those instructions. .
- If the wishes or instructions apply to the health decision to be made

If my Attorney for Personal Care does not know of any wishes or instructions relevant to the health decision to be made then my Attorney for Personal Care Attorney should make health decisions for me that he or she thinks is in my best interests.

My Attorney for Personal Care must consider my values and beliefs that he or she knows about when determining what health decisions to make for me and make the decisions in accordance with the requirements set on page 6 and 7 above..

Grantor and Witnesses Initials _____

REVOCATION

Any prior Power of Attorney for Personal Care or any prior Power of Attorney which gives authority to a Substitute Decision Maker to make decisions for me to which the Ontario *Health Care Consent Act, 1996* applies is hereby revoked.

Signed in _____ this _____ day of _____, _____
in the presence of the two witnesses, each present at the same time.

_____)	
Witness)	
)	
_____)	
Print name and address)	
)	
_____)	_____
)	Grantor
)	
_____)	
Witness)	
)	
_____)	
Print name and address)	
)	
_____)	

PART 2 –WISHES ABOUT FUTURE HEALTH CARE:

I understand that I may communicate my wishes and instructions about my health care to guide the person making decisions for me in the event I am not mentally capable to make decision for myself.

I understand that I may write down these wishes and instructions in this document or elsewhere OR I may communicate these wishes and instructions orally

I understand that if I am in a situation where my wishes or instructions are relevant, my Automatic Substitute Decision Maker or my Attorney for Personal Care must follow my wishes.

I understand that in an emergency situation where healthcare practitioners cannot get consent before providing me care and the health care practitioners are aware of my expressed wishes; my wishes must be followed if relevant.

Wishes and instructions are relevant if:

- I was mentally capable at the time I wrote them down or otherwise communicated them
- If I changed my wishes and I was mentally capable at the time I changed them, then the wishes or instructions that were last communicated are the ones that should be followed.
- If the wishes or instructions apply to the health care decision to be made

If the person making decision for me does not know of any wishes or instructions relevant to the health care decision to be made then he or she should make health decisions for me that he or she thinks are in my best interests.

The person making decisions for me must also consider my values and beliefs that he or she knows about when determining what health decisions to make for me.

My values and beliefs are as follows: **(Complete any of these that you wish to complete)**

I am most proud of:

I would want to be remembered as a person who:

What is most important to me is:

The religious beliefs that I have that I think are important are:

MY CURRENT HEALTH CONDITION

Current illnesses/health challenges that concern me:

My thoughts about how my medical condition might affect my family, friends or others:

My thoughts about what is quality of life to me:

TREATMENT TABLE – MY WISHES ABOUT MY CARE IF I AM DYING

HOW TO COMPLETE

- ✓ For each of the following health situations (found in the first column), imagine that you are in the situation described and require some life-sustaining treatment (found in the top row).
- ✓ If you do not receive this treatment, you would die. If you receive the treatment, the chance that you will live depends on the nature of the medical problem.
- ✓ Even if you recover fully from the medical problem, you would return to the health situation you were in before you developed the further medical problem.

For example, imagine that, at some future time, you suffer from a severe dementia. Then, you develop pneumonia requiring life-saving antibiotics. Without the antibiotics, you would die. With the antibiotics, your chance of surviving depends on the nature and severity of the pneumonia. Of course, even if the antibiotics were successful in treating your pneumonia, you would still have severe dementia. You should then decide whether or not you would want the particular treatment (antibiotics) if you were in this condition (severe dementia).

- ✓ Write your treatment decision ("YES", "NO", "UNDECIDED," or "TRIAL") in the box for every combination of health situation and life-sustaining treatment. Take the example above. If in that situation you would want life-saving antibiotics, if they were the only hope of saving your life, you would write "YES" in the box found where the column "Antibiotics" and the row "Severe Dementia" meet. If you would not want antibiotics in those circumstances, write "NO" in that box.
- ✓ If you are undecided, you would write "UNDECIDED."
- ✓ In some cases, it may be unclear initially whether a given treatment will be beneficial or not. In these cases, you may want to try the treatment for an appropriate period, usually a few days to a couple of weeks. During this time your doctors would monitor and assess the effectiveness of the treatment and determine how beneficial it was for you. If the treatment proved to be beneficial, it could be continued. If not, it could be stopped. If you wish such a treatment trial, then write "TRIAL" in the box. For CPR and surgery, a treatment trial is not appropriate because these treatments are given all at once in a short time
- ✓ **YOU DO NOT NEED TO COMPLETE THIS TREATMENT TABLE unless you are comfortable doing so.**
- ✓ **You may also decide just to talk with your Substitute Decision Maker (whether that's your Automatic Substitute Decision Maker or your Attorney in a Power of Attorney for Personal Care) and tell them what you think about these situations, so that they have some idea about how you would want to be taken care of if you were dying.**
- ✓ **You will be taken care of whether you complete this table or not.**

- ✓ **Even if you complete this treatment table or express any wishes about health care whether written or oral, you may change these wishes AT ANY TIME by just stating orally that you want something else or by changing the written document**

COMPLETING THE TREATMENT TABLE

Write your treatment decision ("YES", "NO", "UNDECIDED," or "TRIAL") in the box for every combination of health situation and life-sustaining treatment. Take the example above. If in that situation you would want life-saving antibiotics, if they were the only hope of saving your life, you would write "YES" in the box found where the column "Antibiotics" and the row "Severe Dementia" meet. If you would not want antibiotics in those circumstances, write "NO" in that box. If you are undecided, you would write "UNDECIDED."

	CPR	Ventilator	Dialysis	Tube Feeding	Life Saving Surgery	Blood Transfusion	Life saving Antibiotics
Current Health							
Moderate Dementia							
Severe Dementia							
Permanent Coma							

- 1 *Moderate dementia* is a condition where a person is quite confused or forgetful. The person is moderately disabled and requires assistance for most activities of daily living throughout the day.
- 2 *Severe dementia* is a condition where a person is extremely confused and has very limited awareness of his or her surroundings. The person is severely disabled and is completely dependent on others for total care.
- 3 *Permanent coma* is a condition where a person is unconscious, and it is expected that the person will never regain consciousness. The person is completely dependent on others for total care.

I understand that that whatever wishes I have written down in this document are GUIDES to my Automatic Substitute Decisions Maker or my Attorney for Personal Care if I become incapable of making for myself my own health decisions to which the Ontario *Health Care Consent Act, 1996* applies

Any wishes written in this documents ARE NOT consents or refusals of consents to any treatment or any health care

Even if I have completed any section in Part 2 , any health practitioners that provide me with care or treatment must either talk to me to get an informed consent to treatment or talk to my Substitute decision maker, whether it is my Automatic Substitute Decision maker or my Attorney for Personal Care.

Confirmation of Part 2

Dated at _____, this _____ day of _____ , _____

Witness who explained
contents of Part 2 of this
Advance Care Plan

Name of Person expressing Wishes
in Part 2 of this Advance Care Plan