**Anticipatory Care Plan Questionnaire**

**Name:**

**Date of Birth:**

**Care Home (if applicable):**

**Who is filling in this form?:**

**Next of Kin:**

What is their relationship to the patient?:

Please stipulate if Power of Attorney or Guardianship are in place:

**What would you want/ What do you think your loved one would want in the event of:**

* The heart suddenly stopping? Would you want efforts to be made to resuscitate?
* An infection not responding to antibiotics?
* An inability to eat and drink?

**Is there anything else you would like us to consider while caring for you/ your loved one?**

For example, if you have strong feeling on admission to hospital or what interventions you would not consider.

**I do/ do not** consent for this information being shared with GP out of hours service, ambulance service and hospital services.

Signed:

Date:

Thankyou for taking the time to do this. We appreciate that it can be difficult and want to assure you that we will continue to care for you/ your loved one to the best of our ability and with your wishes taken into account.

Please email the completed form to: gg-uhb.gp46343@nhs.net