

Advance Care Plan - Contact Information (Queensland)

Name: _____ (or identity label)

Address: _____

Date of Birth: _____ Telephone: _____

Name of agent: _____

Telephone no. of agent: _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Date: _____

If you choose to have an alternate agent:

Name of alternate agent _____

Telephone no. of alternate agent _____ (Home)

_____ (Mobile)

_____ (Work)

Relationship: _____

Date: _____

Your Advance Care Plan includes the following documents:

Medical Enduring Power of Attorney Yes / No

Statement of Choices Yes / No

Refusal of Treatment Certificate Yes / No

Certified copies of your Advance Care Plan have been given to:

(complete as many lines as applicable)

1. _____

6. _____

2. _____

7. _____

3. _____

8. _____

4. _____

9. _____

5. _____

10. _____