Think ahead
Speak for Yourself

## 2.3 EMERGENCY SUMMARY FORM

**This form concerns your preferences for resuscitation and life-sustaining treatment, and is for the attention of paramedics and out of hours providers in case of an emergency.**

**Patient Name:** _____ **Date of Birth** _____

**Address:** _____

**Emergency contact persons:** _____ **Contact phone numbers:** _____

_____ _____

**Location of complete Think Ahead Form:**

_____

**I have prepared an Advance Healthcare Directive:** Yes ☐ No ☐

**It can be found:** _____

**I have nominated a Patient-Designated Healthcare Representative:** Yes ☐ No ☐

**Contact details:**

_____

**I have appointed an attorney to make healthcare decisions:** Yes ☐ No ☐

**Contact details:**

_____

**Diagnosis:** **Are you receiving ongoing treatment/medication for this?**

1. _____ _____
2. _____ _____
3. _____ _____

**Details:** **Where do you keep your medications?**

_____ _____

_____ _____

Date Completed: _____ Date Reviewed: _____

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## 2.3 EMERGENCY SUMMARY FORM

**Continued**

### FOR PARAMEDICS

**Resuscitation Preferences;**
**Please indicate the option(s) most relevant to your present condition.**

I understand that I may not benefit from attempted CPR/***defibrillation****, Therefore:

- ☐ **I do NOT want CPR/Defibrillation to be attempted even if it will result in my death.**

  **OR**

- ☐ **I would like CPR / Defibrillation to be attempted, if it might be medically beneficial.**

### FOR GPs AND OUT OF HOURS PROVIDERS



**Key Treatment Decisions**
(Please also see above section on resuscitation preferences)

- ☐ **I would like such life-sustaining treatments that my treating healthcare professionals consider necessary and appropriate.**

  **OR**

- ☐ **I do NOT want life-sustaining treatments at all. If life sustaining treatment has started, I request that it be stopped, even though this will result in my death.**

Regardless of the preferences expressed above, I understand that in all cases basic care will be provided.

**Any other relevant information:**

This Think Ahead Emergency Summary Form will guide paramedics and out of hours health professionals in making emergency decisions. It has been developed in association with the Pre-Hospital Emergency Care Council (PHECC) and with input from medical practitioners and legal professionals.

**This form must be signed by you.**

Your Name: _____ Your Signature: _____

** See Glossary*