



Speak for Yourself

My form

Name:



Think



Talk



Tell



Record



Review

THE BENEFITS OF THINKING AHEAD AND THINGS TO CONSIDER

- What if a day comes when you are unable to make decisions for yourself?
- What if you are suddenly taken ill, are involved in an accident or lose your ability to think clearly or independently?
- Do your closest family members or friends really know your wishes?

“ The purpose of Think Ahead is to guide members of the public in discussing and recording their preferences in the event of emergency, serious illness or death. ”

The Think Ahead Form is a planning document for use by adults at all life stages. It helps you to think about discuss and record your preferences regarding all aspects of your end of life care. It encourages you to ensure that those closest to you are aware of these preferences. A time may come when you are unable to express your wishes and preferences. By using Think Ahead your wishes will be clear to those caring for you or managing your affairs.

There is no obligation to fill out the complete form; it is entirely voluntary and you should only fill out those sections you are comfortable with. The most important information you can provide includes details about your identity (name, address and so on) and who you would like to be contacted in the event of an emergency. If you decide to complete the entire form, we encourage you not to fill it all out at once. Instead, take your time and complete it over several sittings, taking time to think about it and speak to others if you wish.

Medical care is a very personal thing. Our preferences are shaped by our individual beliefs and values. Unless you expressly record your care preferences, your family members or those caring for you may not know your wishes, and disagreements may occur. YOU can provide guidance by 'Thinking Ahead'. Section 2 of this

form focuses on your health care preferences. You can make an Advance Healthcare Directive and it is not necessary to obtain legal advice to do so. To create an Enduring Power of Attorney, you do need legal advice. If you cannot afford to pay for legal services, you can apply for free legal aid to do this.

Your GP or treating doctor will be central to your care. We encourage you to discuss your preferences with them and to leave a copy of Section 2 with your doctor when completed. However, in an emergency situation, the doctor treating you may be unfamiliar with you, or your care preferences. In those situations, a clear written record of your wishes can be very useful.

Finally, there are many different factors, such as age and illness, that can change your preferences over time. If you change your mind, you can update your wishes on the form at any time. Regular updating of your wishes is important particularly should you experience a medical emergency or life limiting illness. For that reason, we encourage you to view this form as a document that can change to reflect your preferences. Therefore, you should review your Think Ahead Form either annually, or as often as is appropriate for you.

As the Irish Hospice Foundation is a national charity a charge of €4 per copy will apply to cover our costs. Special provision will be made for those unable to pay.

 Text TA to 50300 to donate €4

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Glossary

The Think Ahead Form was created by the Irish Hospice Foundation in good faith for general information purposes only and does not constitute legal or professional advice. The information contained in this form may be time sensitive and is subject to change without notice due to changes in legislation. Every effort has been made to assure the correctness of all information contained in the form at the time of publication. As a result older versions of the form may be out of date. If in doubt, please contact The Irish Hospice Foundation or your solicitor for specific legal advice on a particular matter.



Fill out only information you feel comfortable providing. Once you have filled out the form, store it in a safe place. Make sure to tell those closest to you about your wishes, and where to find the form in an emergency.

Information Key





SECTION 1. Key Information In Case of Emergency (ICE)

4

This section provides key information about you that can be used to inform your treatment and care in case of emergency.

1.1 Personal Information

Name:

Phone Numbers:

Nickname:

Gender:

I would prefer to be called by my:

First Name

Surname

Nickname

☐
☐
☐

Date of Birth:

Address:

Place of Birth:

PPS No./Universal Health Identifier No*:

* Not yet available in Ireland

1.2 Emergency Contacts

Who would you like to be contacted in the event of an emergency?

It is important to name more than one person if possible, in case someone is not contactable. You may decide to nominate a family member, friend, your doctor or a neighbour as your contacts. **It is very important that you tell them that you are naming them as your emergency contacts, and that you discuss what is involved with them.**

1.

Name:

Relationship:

Phone:

Address:

2.

Name:

Relationship:

Phone:

Address:

3.

Name:

Relationship:

Phone:

Address:



Need Help?

If at any point you need help completing this form, please visit the Think Ahead website: www.thinkahead.ie

1.3 Emergency Information

Please list all known allergies:
(e.g. Wasp sting, penicillin or food)

Existing conditions:
(e.g. Diabetes, chronic obstructive pulmonary disease (COPD))



Have you been hospitalised for a serious illness in the last 5 years?

Yes ☐

No ☐

If yes, please list the reason for hospitalisation, date and hospital attended:

**Reason for
Hospital Visit/Stay:**

Dates From – To:

**Hospital/Clinic
attended**

1.4 General Practitioner (GP)/Treating Doctor

Name:

Home/Office Phone:

Address:

Mobile Phone:

Email:



1.5 Health Insurance Information

Do you have a medical card?

Yes ☐

No ☐

General Medical Services (GMS) Number:
(on the front of your card)

Private Health Insurance

Do you have private Insurance?

Yes ☐

No ☐

Name on Policy:

Name of Insurance Company:

Policy Number:

Additional Notes



Reviews

Signature:

Date Reviewed:

Signature:

Date Reviewed:

Signature:

Date Reviewed:

Signature:

Date Reviewed:

Medications



If you are taking any ongoing medication, you might consider asking your pharmacist to print a record of these on your next visit which you can staple to this page. Alternatively you can list those medications below.



SECTION 2. Care Preferences

This section provides key information about you that can be used to inform your medical treatment and care in case of emergency.

This information should be shared with: (Please tick all that apply)

☐ Family ☐ Loved Ones ☐ GP, Nurse, Carer ☐ Other

- How would you like to be cared for if you were ill?
- Who would you like included in discussions about your medical condition or care?
- Are there cultural/spiritual preferences or religious beliefs that you would like the healthcare staff to consider in caring for you?

These are important questions. They can be answered here so that you are given the best possible care and consideration by the staff at a hospital or in another care setting.

This part of the form has three separate sections.

1. The first section deals with your care preferences should you become ill and are unable to communicate your wishes.
2. The second section is an Advance Healthcare Directive. This allows you to set out your preferences about medical treatments you **do not want** to receive in the future in case you cannot communicate your wishes at that time. It also allows you to nominate someone, called a **Designated Healthcare Representative***, who you have authorised to interpret or make your healthcare decisions. If you have appointed an **attorney(s)*** under an **Enduring Power of Attorney*** to make healthcare decisions on your behalf, it is important to state what authority you have given your attorney(s) or **representative.***
3. The final section is an emergency summary sheet containing important information. **Remove it from the rest of the form and store it in an easily accessible place for use in an emergency situation.**

We recommend that you speak to a healthcare professional before completing this section of the form as he or she may be the person best placed to give you the information you need when deciding about the care and treatment you would like.

2.1 Care Preferences Communication/Information

There may be some instances when your medical condition may prevent you from being involved in discussions about your health. You might be unconscious, or you might be conscious but unable to understand retain, use, weigh up the information needed to make a particular decision at a specific time or to communicate your wishes. With this in mind:

Would you like a relative, friend, or independent advocate to be present with you for conversations with the medical team, or at key events in your care?

Yes ☐ No ☐

* See Glossary



Need Help?

If at any point you need help completing this form, please visit the Think Ahead website: www.thinkahead.ie



If yes, please give the name and relationship of that person(s):

Name:

Relationship:

Phone:

Email:

Name:

Relationship:

Phone:

Email:

Care Preferences

If your condition is deteriorating and is life-limiting, who should talk to any children, or other close family and friends, about the extent of your illness and the possibility of your death?

Please Specify...

Cultural/Spiritual Preferences and Religious Beliefs

Are there any cultural/spiritual preferences or religious beliefs or rituals that you would like to be considered as part of your care? If so please list these below:

Is there someone from your cultural community or religious community that you would like to be informed if you are seriously ill? If so please give that person's name and contact details.

Name:

Role:

Phone:

Email:

Other Wishes

Think about the place you would most like to be cared for if you were nearing death.

Please indicate your first preference by putting the number '1' beside that option. Likewise, please put the number '2' beside your second preference, '3' beside your third preference and so on. You may change your mind over time and you may also find that when the time comes your preferred place of care may not be available.

- **Home** ☐
- **Hospice** ☐
- **Hospital** ☐
- **Nursing Home** ☐
- **Other (please specify)** ☐

Name of preferred Hospital/Hospice/Nursing Home:

Is there anything in particular (e.g. photos, favourite music, rituals, prayers etc.) you would or would not like in your final days of life? [Please list preferences:](#)

What I would like:

What I would not like:

Besides those wishes already expressed, I would like the following requests or preferences to be considered.



2.2 My Advance Healthcare Directive

An **Advance Healthcare Directive*** (AHD) is a written statement made by a person who has reached the age of 18 years with capacity (the ability to understand, retain and use or weigh up the information in order to make a decision). It sets out their will and preferences about treatment decisions that they **do not want** to receive in the future, if a time comes where they lack capacity to make such decisions or cannot communicate their decision by any means.

The Assisted Decision-Making (Capacity) Act 2015 was enacted in December 2015. It sets out the requirement for making a valid AHD.

AHDs mainly concern a person's right to refuse treatment even if the refusal is considered by others to be unwise, made for non-medical reasons or may result in death, provided that the person at the time of making the AHD had the capacity to make the AHD.

The 2015 Act provides that a request for specific treatment set out in an AHD is not legally binding (a person cannot demand treatment that is unnecessary) but it must be taken into consideration if it relates to treatment that is relevant to the medical condition of the maker of the Advance Healthcare Directive.

If the AHD is valid and applicable (complies with the formalities and specifies the criteria) to the specific treatment then healthcare professionals are legally bound to follow them. An AHD can be revoked or altered in writing provided the person has the capacity to do so. Any alteration of an AHD must be signed and witnessed in the same manner as the original AHD.

An AHD also allows you to nominate a Designated Healthcare Representative. This is an individual who you will authorise to interpret your AHD or to make healthcare decisions on your behalf. They can have such authority as you decide to give them, up to and including the power to consent to/refuse life-sustaining treatment.

There is no obligation to make an Advance Healthcare Directive. It is completely your decision. This section simply assists you in setting out the preferences you may have in a way which will meet the requirements for a valid Advance Healthcare Directive.

Importantly, an Advance Healthcare Directive will come into effect only if you lose capacity* and are unable to communicate your healthcare decisions.

You may like to either speak to your GP or primary medical professional before completing this or to inform them that you have completed this and what your wishes are.

Designated Healthcare Representative

If you wish you can appoint a Designated Healthcare Representative. This person may be a trusted family member, close friend or independent advocate who will act on your authority. Therefore, it is important to speak to him or her regarding the care you would like or not wish to have. **You do not have to appoint a representative and can merely set out your wishes in an Advance Healthcare Directive provided the formalities are followed, signed and witnessed by two persons.**

If you decide to nominate a representative, they must be over 18 years of age, not someone who is caring for you in return for payment, and not someone who owns or works in a residential or healthcare facility where you are living. It is necessary for this person to sign the directive and confirm their willingness to act on your behalf.



* See Glossary



Your Designated Healthcare Representative

Name:

Relationship:

Address:

DOB: / /

Phone:

Email:

I am willing to to act in accordance with my authority under this Advanced Healthcare Directive

Signature of Designated Healthcare Representative

Alternative Designated Healthcare Representative

(Optional - In the event that the person above is unavailable)

Name:

Relationship:

Address:

DOB: / /

Phone:

Email:

I am willing to to act in accordance with my authority under this Advanced Healthcare Directive

Signature of Designated Healthcare Representative

I have given my Designated Healthcare Representative the following authority:

- ☐ Power to advise and interpret what my wishes are regarding treatment which I have set out in this Advanced Healthcare Directive.
- ☐ Power to ensure that the wishes I have expressed in this Advance Healthcare Directive are carried out based on my will and preferences according to my Advanced Healthcare Directive.
- ☐ Power to consent to or refuse medical treatment on my behalf, up to and including life-sustaining treatment based on my will and preferences according to my Advance Healthcare Directive.



Please state your directives with respect to life-sustaining treatment and **cardiopulmonary resuscitation*** (CPR) here. These wishes will have an impact if you become unable to take part effectively in decisions regarding your medical treatment.

Life-Sustaining Treatments

Life-sustaining treatment* is treatment which replaces, or supports, a bodily function which is not operating properly or is failing. Where someone has a treatable condition, life-sustaining treatments can be used temporarily until the body can resume its normal function again. However, sometimes the body will never regain that function.

If there is no prospect for my recovery:

- ☐ I wish to have whatever life-sustaining treatments that my healthcare professionals may consider necessary and appropriate.
- OR**
- ☐ I wish to have whatever life-sustaining treatments that my healthcare professionals may consider necessary unless this will require the following treatments, which I do not wish to receive, even if this refusal will result in my death:
- ☐ Being placed on a mechanical ventilator/breathing machine
 - ☐ Dialysis
 - ☐ Artificial feeding intravenously
 - ☐ Artificial feeding through a tube in the nose (nasogastric tube)
 - ☐ Artificial feeding through a tube in the abdomen (PEG tube)

There may be some life-sustaining treatments which you would not want to receive in any situation. These may include dialysis, being placed on a ventilator or artificial feeding. If you develop an infection, you may decide not to have *intravenous antibiotics** and also, you may decide not to have oral antibiotics. If there are particular life-sustaining treatments which you do not wish to receive, please mention these below. If you wish to refuse life-sustaining treatment you need to specifically state this and also state that the directive is to take effect even if your life is at risk. **In addition to setting out the specific treatment it is also necessary to specify the specific circumstances regarding the refusal of such treatment, e.g. If I have terminal cancer, I do not wish to receive chemotherapy; If I am in a very serious accident, I do wish to be placed on a ventilator.**

Cardiopulmonary Resuscitation (CPR)

In order to make decisions regarding resuscitation preferences, it is important to discuss your health with your doctor as some conditions will not benefit from CPR.

Please tick your preference:

It has been explained to me by Dr _____
that I would not benefit from attempted CPR and I understand this.

Therefore:

- ☐ I do NOT want CPR **OR**
- ☐ I would only like CPR attempted if my doctor believes it may be medically beneficial.



Other Preferences

There may be other situations you would find unacceptable in relation to your health. You can give details here. It is important to specify specific treatments you do not want and the circumstances in which your refusal of treatment is to apply.

This form must be signed by you and by 2 witnesses. Both of these people **must be over 18**, and **at least one of them must not be a member of your family** and should not be your attorney(s) or Designated Healthcare Representative.

Your Signature	Date
Witness 1 Signature	Date
Witness 2 Signature	Date
Your DOB (the directive maker)	

Your wishes may change over time. For this reason we strongly encourage you to review this part of the form annually or as often as is appropriate for you. Please also remember that if you do make any changes to your Advance Healthcare Directive, these must be witnessed in the same way as the original.



Reviews

Signature:

Date Reviewed:

Signature:

Date Reviewed:

Signature:

Date Reviewed:

Signature:

Date Reviewed:

* See Glossary



Remember

Irrespective of any decisions about CPR and life-sustaining treatment, you will receive **basic care***, which will include normal nutrition and hydration as well as care to relieve pain and relieve any suffering.

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 Designated Healthcare Representative: Yes ☐ No ☐

Contact details:

I have appointed an attorney(s) to make healthcare decisions: Yes ☐ No ☐

Note: If the same healthcare decisions are set out in an AHD and an EPA, it will be the AHD document that will be regarded as the valid direction to be followed. The refusal of life-sustaining treatment can only be provided for in an AHD and not in a EPA.

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:

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.

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

Any 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:

SECTION 3. Legal

PRIVATE

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This section of the Think Ahead Form provides key information concerning your legal affairs.

This information should be shared with: (Please tick all that apply)

☐ Family ☐ Legal/Accounting ☐ GP, Nurse, Carer ☐ Other

3.1 Legal

Have you appointed an attorney(s) under an Enduring Power of Attorney? (For more information about Enduring Power of Attorney and how it may be useful to you, visit www.thinkahead.ie)

Note: You can appoint an attorney(s) when you have capacity to do so in an Enduring Power of Attorney (EPA) and give the attorney(s) authority to make decisions on your behalf when you lack the capacity to make decisions for yourself.

Yes ☐ No ☐

Please name the person(s) appointed as attorney(s):

Are there any limitations on the level of authority that you have given your attorney(s)? For instance, are they responsible for just one area of your estate, finances, personal care, healthcare, or for all of your affairs.

Yes ☐ No ☐

Have you given your attorney(s) authority to look after your:

- ☐ Property and affairs (General Authority or Specific Authority)
- ☐ Personal welfare decisions which may include healthcare decisions (Specify the matters included)

Note: You cannot include any decisions in relation to life-sustaining treatment in an EPA, this can only be done in an AHD.

Have you made a **Will**? (For more information on how to make a will visit www.thinkahead.ie)

Yes ☐ No ☐

Executor* contact details:

Is there any family member for whom financial or other provision needs to be made? If so, you should discuss the possibility of creating a **trust*** for that person with a legal advisor.

Have you appointed Guardians for any children under 18? If so, please specify.
Names _____ Contact details _____


* See Glossary


Need Help?

If at any point you need help completing this form, please visit the Think Ahead website: www.thinkahead.ie

SECTION 4. Financial

PRIVATE

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This section of the Think Ahead Form provides key information concerning your financial affairs.

This information should be shared with: (Please tick all that apply)

☐ Family ☐ Legal/Accounting ☐ GP, Nurse, Carer ☐ Other



It is important to note that information concerning your financial affairs is of a particularly sensitive nature, and you may wish to keep this part of the form separate from the rest. It may be useful to consider filing this part of the form with your solicitor or creating an Enduring Power of Attorney for property and financial affairs. This means you can select one person to be authorised to manage your financial affairs should you be unable to do so. For more information about this, please see www.thinkahead.ie

To make it easier for you and those who assist you in the event that you lack capacity or after your death, please provide the following information (if relevant).

4.1 Bank Accounts

Name on Account:

Bank:

4.2 Insurance (Home, property, car, etc.)

Item Insured:	Account Number:	Policy Number:

4.3 Life Assurance

Provider:

Account Number:



Need Help?

If at any point you need help completing this form, please visit the Think Ahead website: www.thinkahead.ie

4.4 Credit Cards

Type:

Name of Financial Institution:

4.5 Tax Affairs

Details of the Revenue Tax Office/District that deals with your tax affairs

(This information is available on your annual certificate of tax credits and other correspondence you receive from the Revenue Commissioner)

4.6 Pensions

Employment/Job-related Pension:

Reference or Account Number:

Private/Personal Pension:

Name of Pension Scheme/Provider
Reference or Account Number:

Social Welfare Pension:

Reference or Account Number:

4.7 Mortgage Documents/House Deeds:

Property:

Location of Documents:

Note: If your title is registered, you may not have title documents in your possession as details of your title to property may be held by the Property Registration Authority.

4.8 Other Assets/Debts

List other assets (property, shares, etc.) and liabilities (debts) that you may have here.



Other professional(s) that should be contacted with regard to your financial affairs (e.g. accountant, tax consultant, investment advisor etc.)

Name:

Role:

Contact Information:

[illegible]

SECTION 5. When I Die

This section of the Think Ahead Form will allow you to record private and personal wishes for what you would like to happen after you die, such as whether or not you would like to donate your body or organs, where and how you would like to be buried and how you would like to be best remembered.

It will allow you to consider topics, open up conversations that you might otherwise find awkward or difficult, or just capture details in one central place.

This information should be shared with: (Please tick all that apply)

☐ Family ☐ GP, Nurse, Carer ☐ Other

In this section, you can record your preferences in relation to what happens after you die. This can include:

- **Organ donation**
- **Body donation**
- **Hospital post-mortem**
- **Funeral ceremonies and burial arrangements**

5.1 Organ Donation

Organ donation and transplantation currently saves the lives of between 200 and 250 people in Ireland every year. Each organ and/or tissue donor could save the lives of up to 8 people who are in the end-stage of organ failure.

Organs that are suitable for transplant are the heart, heart valves, kidneys, liver, lungs and pancreas. You may wish to donate all, or some, of these. Only those which have been specifically consented to are taken for transplantation.

Having a medical condition does not necessarily prevent you from becoming a donor, however, this will be decided by a healthcare professional on a case-by-case basis. It is advisable to inform your loved ones of your wishes in relation to organ donation as they may be consulted on this matter. If you do not wish to donate organs you should state this here (in 'Other' question).

The removal of organs is carried out with the same care and respect as any other operation and organ donation does not disfigure the body or change the way it looks. Nor does it cause any delay to funeral arrangements.

Provided they are suitable for donation at the time, I would like to donate the following:

☐ Kidneys ☐ Liver ☐ Heart/lungs ☐ Pancreas ☐ All

Other (please specify). If you do not wish to donate organs you should state this here:

Note: You cannot volunteer to donate your body to medical science if you have already chosen to donate your organs. This means that you should complete either section 5.1 or section 5.2



5.2 Body Donation

Medical research is a vital way in which the health profession can learn more about the human body and how to treat illness.

Arrangements for donating your body for academic purposes in Ireland must be made with one of the following medical educational facilities prior to your death: University College Dublin, Trinity College Dublin, The Royal College of Surgeons in Dublin, University College Cork, University College Galway.

There are some medical conditions that can prevent acceptance as a donor. These include: Hepatitis, HIV and Tuberculosis. Education facilities will not be able to accept a body donation if a post-mortem has been carried out. For these reasons, it is also important that you make alternative arrangements in the event that remains are unsuitable for donation.

There is no upper age limit for donation, nor does amputation prohibit the acceptance of a body for medical research.

Bodies that have been donated for medical research are normally released for burial or cremation between 1 and 3 years from the time of death.

If you have made prior arrangements with an education facility to donate your body for the study and research of human anatomy for the advancement of medical science please give details below:

Name of Educational Facility:

Address:

Contact Name:

Contact Number:

5.3 Post-Mortem

A post-mortem is a medical examination carried out on the body after death. It can provide information that may be valuable for your family, your treating doctor, or both.

There are 2 main circumstances in which a post-mortem may be carried out:

1. The majority of post-mortems carried out in Ireland are **coroner's post-mortems**. Where a death is sudden or unexplained, the local Coroner must be informed and he/she may direct that a post-mortem be carried out in the course of the investigation before a death certificate may be issued. **Consent of next of kin is not required where a post-mortem is requested by a Coroner.**
2. The deceased person's doctor, or sometimes the family of a deceased person, may request that a post-mortem be carried out. This is what is called a **hospital post-mortem**.

If you have strong preferences about a hospital post-mortem you may wish to discuss these with your next of kin.



5.4 Funeral and Burial Arrangements

Are there any specific individuals, friends, acquaintances, groups or organisations with which you have been involved that you would like to be notified in the event of your death?

Please include all relevant details such as name, address, telephone number and e-mail address.

Are there any churches, church members or religious/spiritual or other organisations you would like to be notified in the event of your death?

Yes ☐

No ☐

Please specify:

I would like the following person to be responsible for making my funeral arrangements:

Name:

Address:

Phone:

Email:

I have made pre-paid funeral arrangements:

Yes ☐

No ☐

If Yes, please give details:



My preferred funeral director is:

Name:

Phone:

Address:

I wish to be: **Please Circle**

A) Buried

B) Cremated

Preferred cemetery or crematorium:

Do you own/are you entitled to be buried in a particular grave? **If Yes, please give details:**

I would like my ashes to be placed in the following location:

Please specify the location of the grave papers below:

Type of Ceremony:

☐ Civil

☐ Religious

☐ Elements of Both

I wish my funeral ceremony to be held at:

I would like the following person to be the Celebrant/Master of Ceremonies:



Please state, in order of preference, anything in particular you might like in your funeral service or ceremony (e.g. prayers, poems, readings, tribute, words on gravestone, flowers, music, donations to charity, refreshments, etc.). This might help guide your bereaved loved ones at a difficult time. However, also bear in mind that they may not be able to fulfil all of your wishes. For ideas and resources please see the Think Ahead website at **www.thinkahead.ie**.

Please state preferences:

APPENDIX

1. Where to find my important documents

Details:	Place Kept:
Will/ Trusts	
Insurance Policies	
Pensions	
Bank Accounts	
Credit Cards	
Mortgage Documents/House Deeds	
Birth/Marriage Certificates	
Enduring Power of Attorney	
Advanced Healthcare Directive	
Grave Papers	
Other important documents	

2. I have the following social media accounts:

Facebook ☐ Twitter ☐ LinkedIn ☐ Instagram ☐ Google+ ☐ Myspace ☐
 Other ☐ Please specify _____

3. Subscriptions

I have the following subscriptions/standing orders which should be reviewed:

4. Pets

I have the following pets that will need to be cared for:

GLOSSARY

Advance Healthcare Directive	An Advance Healthcare Directive is an expression made by a person who has reached the age of 18 years who has capacity in writing (to include voice, video recording and speech recognition technologies) of their will and preferences concerning specific treatment decisions that may arise if he or she subsequently lacks capacity. An Advance Healthcare Directive is legally binding (therefore certain formalities must be followed) when a person writes down what treatments they would refuse in the future and the circumstances in which the refusal is intended to apply. The Assisted Decision-Making (Capacity) Act (2015) provides that a request for specific treatment is not legally binding but should be followed if relevant to the medical condition for which treatment is required. Codes of practice are being developed to indicate the formalities required to comply with the provisions of the ADMC Act (2015).
Attorney (Under an Enduring Power of Attorney)	The name given to a person(s) you have given authority to manage your affairs/make healthcare decisions on your behalf in the event that you lack the capacity to make those decisions for yourself. An attorney(s) appointed under an Enduring Power of Attorney can be given authority to make decisions related to property and affairs and/or personal welfare. Personal welfare can include healthcare decisions but not the refusal of life-sustaining treatments.
Basic Care	This includes, but is not limited to, warmth, shelter, oral nutrition and oral hydration and hygiene measures.
Capacity (Decision-Making Capacity)	The ability of a person to understand, retain, use or weigh up the information needed to make a particular decision at a specific time or to communicate his/her wishes.
Cardio Pulmonary Resuscitation (CPR)	An emergency manoeuvre which is applied directly to the chest of a person whose heart has stopped. It manually preserves brain function until further measures can be taken to restore regular blood circulation and breathing.
Defibrillation	Treating the heart with a dose of electricity when it has stopped. The device used to do this is called a defibrillator.
Designated Healthcare Representative	A person you may choose to nominate in an Advance Healthcare Directive. This person will have whatever authority you have given them in your Advance Healthcare Directive and he or she must sign the Advance Healthcare Directive to confirm his or her willingness to act in accordance with your directive.
Dialysis	A process for removing waste and excess water from the blood. It is mainly used as an artificial replacement for kidney function in a person whose own kidneys are failing or have failed.
Enduring Power of Attorney	An Enduring Power of Attorney is a document, drawn up with a person who has capacity, which gives another person(s) the power to make general and/or specific decisions. This comes into effect when a person lacks decision-making capacity and their enduring power is registered with the Wards of Court Office. An EPA created on the commencement of the Assisted Decision-Making (Capacity) Act 2015 will be registered with the Director of the Decision Support Service. No decision in relation to life-sustaining treatment can be included in an EPA.
Executor(s)	This is a person(s) named in a Will that will have responsibility for making sure the directions contained in the Will are carried out and your estate is properly administered.
Intravenous	A method of administering medication or fluid to a patient by delivering it directly into their veins.
Life Assurance	This is an insurance product where periodic payments are made to an insurance company, in return for which they either make a lump sum payment to your family or meet a particular liability (e.g. mortgage) if you die.
Life-sustaining treatment	Treatment which replaces, or supports, a bodily function which is not operating properly or failing.
Nasogastric tube feeding	A method of artificial feeding in which a tube is passed through the nose, past the throat, and down into the stomach.
Palliative Care	An area of healthcare which aims to improve the quality of life of patients through the prevention and relief of suffering. It can be appropriate for patients in all disease stages, from those undergoing treatment for curable illnesses to those nearing end of life.
PEG tube feeding	Percutaneous endoscopic gastrostomy. This is a method of artificial feeding in which a tube is passed into a patient's stomach.
Treatment	Means an intervention that is or may be done for a therapeutic, preventative, diagnostic, palliative or other purpose related to the physical or mental health of the person, and includes life-sustaining treatment, artificial hydration and artificial nutrition.
Trust	This is where property is held "on trust" for the benefit of another person. Often, people create trusts in their lifetime or in their Will setting out how money or property should be handled for minor children or other family members who, for some reason, cannot take responsibility for it themselves.
Ventilator	A machine which provides a mechanism of breathing for a patient who cannot breathe properly for themselves. It mechanically moves breathable air in and out of the lungs.
Will	This is a legal document which sets out in writing your directions as to how your property/possessions should be distributed upon your death.



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