**Patient Contact Numbers:**

Telephone No:

Mobile No:

Mob:



Anticipatory Care Patient Alert

**Patient Contact list:**

Carer/family contact:

Telephone No:

Additional Keyholder:

Telephone No:

**Access Information** (if relevant)

**Power of Attorney:**

Is there a **Power of Attorney**? Yes  No

**Guardianship:**

Is there a **Guardianship**? Yes  No

Contact details of person with Welfare PoA /Guardianship:

...................................................................................................

...................................................................................................

**Incapacity:**

Does the patient have capacity? Yes  No

Has AWI form been completed? Yes  No

**Other Agencies involved**

Named community Nurse:

Home Care Contact:

Help Call contact number (if available):

**Resuscitation Status**

Has Resuscitation been discussed with patient? Yes  No

And with the Family? Yes  No

Is resuscitation appropriate? Yes  No

Has Do Not Resuscitate been agreed? Yes  No

DNACPR form completed? Yes  No

**Medications in the home**

Are rescue medications kept in the house ( eg steroids, antibiotics, JIC)? Yes  No

*If so please list:*

JIC Medications Done

Medication Review Done

Polypharmacy Review Done

Patient details

Affix sticker/label here

**GP: XXXXXXX**

What is the **Preferred Place of Care**?

If hospital admission is necessary, which hospital should be first choice?

**Anticipatory Care Plan should patient’s condition(s) deteriorate(s)?**

Patient’s wishes regarding ceiling of therapy:

Intensive Care

Medical/Surgical HDU

Ward-based care including Oxygen/IV fluids/IV antibiotics

Remain at home/Care home for oral antibiotics/bloods testing

Symptomatic Care

What is the plan should the main carer fall sick?

Has the ACPA been discussed with the family? Yes  No

Have end of life choices been discussed? Yes  No  If a living will is in place, who holds copies?

**eKIS Consent**  Date of ACPA: ........................................

**Patient Consent**

Method of Identification of Patient *(for payment purposes)*:

Care Home Resident Yes No 

I have read the above information and give my consent for this information, and any updates, to be shared within the Highland Out of Hours Service and other Health or Social Care Professionals.

Patient Name: Patient Signature: Date:

Health Professional Name: Health Professional Signature: Date:

If the patient is unable to sign this, have they otherwise given their witnessed consent Yes  No

If the patient is unable to give consent, has the Adults with Incapacity Act form been completed? (see incapacity section above)

**Name:**

**Address:**

**Date of Birth:**

**GP Surgery: XXXX Medical Practice**



Anticipatory Care Patient Alert