**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:

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

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**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