Yukon
Health and Social Services

RESUSCITATION AND CARE

Background Information for Completing the Form

This form allows you to clearly state the type of care you want in the event you can no longer make the decision for yourself. This form assists health care providers and family members to carry out your wishes. If you want to appoint a proxy (substitute decision-maker) in addition to stating your wishes, you should make an Advance Directive. If you do not make an Advance Directive, a family member will make a care decision for you only when you are not mentally capable of making your own decision.

Filling out this form may be difficult for many people. We don't like to think of our death, yet it is an inevitable and natural part of life.

Take the time to consider the options outlined in this form and discuss the options with your health care providers, family and friends.

Once you complete this form, make sure that a copy goes with you if you are moving from hospital back home or from home to the hospital or a continuing care facility. Your doctor should also have a copy.

If you change your wishes about your care, please tell your doctor and/or nurse right away and destroy and/or replace this form. Your most current wishes made while you are still mentally capable will be followed whether those wishes are made in writing or verbally. It is up to you to make sure that people are aware of your wishes.

Resuscitation is short for Cardiopulmonary Resuscitation (CPR) and includes chest compressions, drugs, electric shocks and artificial breathing to restore a heartbeat. Television shows give the impression that CPR is highly successful, when in actual fact, survival rates vary from 0 to 20% depending on the person's condition. Discuss whether CPR is appropriate for you with your doctor.

Planned Home Deaths

For planned home deaths, think about whom you want to be involved at the time of death. See the suggestions listed below. At the time of a planned home death, DO NOT CALL 911 or Emergency Medical Services (ambulance).

In the event that someone does call an ambulance, your family should have this form available to show the ambulance attendants.

Planning Ahead

- Discuss the option of an in-home death with your doctor and/or registered nurse.
- Make a plan with your doctor or nurse that includes:
  - Who if anyone will be called at the time of the death (note that it is not necessary for a doctor or nurse to pronounce death in the Yukon);
  - Which funeral home will be called to transport the deceased or alternate arrangements if there is no funeral home in your community.
- Communicate your plan to family, friends and others such as your spiritual advisor so they may support your decisions and respect your wishes.
- Make sure that the original copy of this form is easily available in your home. If you leave your home for any reason, take this form with you.

At the Time of Death

- DO NOT CALL 911, the ambulance, coroner, or police.
- CALL family, friends, and the spiritual advisor you would like to have present.
- CALL the funeral home when you are ready. There is no rush to call if you wish to take extra time.

People to Call **Name** **Phone No.**

Doctor or Nurse _____

Funeral Home _____

Spiritual Advisor _____

Hospice Society _____

Family and Friends _____

_____

_____

this form is available in French
également disponible en français

RESUSCITATION AND CARE

INDIVIDUAL INFORMATION

Name: _____
(please print)

Address: _____
(street address)

Health Care Number: _____

Telephone Number: _____ **Date:** _____

WISHES (1)
RESUSCITATION
(check only one box)

If I have no pulse and am not breathing:

☐ **RESUSCITATE** **OR** ☐ **DO NOT attempt or continue any RESUSCITATION (DNR)**

WISHES (2)
CARE
(check only one box)

If I have a pulse and am breathing:

☐ **COMFORT MEASURES ONLY:** These include nursing care, medication for managing symptoms including pain, oxygen, hydration except by intravenous (IV) therapy, mouth care, positioning, warmth, emotional and spiritual support, and other measures to relieve pain and suffering. No other medical treatment will be provided.

OR

☐ **SPECIFIED MEDICAL CARE:** In addition to comfort measures, I would want the following if recommended by my health care providers. This may necessitate transfer to a hospital.

___ antibiotics
___ other medications
___ radiation
___ tube feedings
___ defibrillation (shock to heart)
___ intubation (for breathing)
___ surgery
___ intravenous therapy
___ chemotherapy
___ kidney dialysis
___ blood transfusions
___ other treatment _____

OTHER SPECIFIC WISHES RELATED TO END-OF-LIFE CARE

_____
_____
_____
_____
_____
_____
_____

Please provide Original to Patient/Substitute D-M, Copy to Physician or Nurse and Copy to Facility for placement on chart (where appropriate)

RESUSCITATION AND CARE

SIGNATURES

1. If the person making the wishes is capable of consenting ***(sign 1. only)***

OR

2. If the person the wishes pertain to is not capable of consenting ***(sign both 2(a) and 2(b))***

1. If you are mentally capable of consenting to the directions given in this form, only your signature is required below.

I have discussed my condition with my health care provider and understand the information and options provided. The above directions reflect my wishes in the event I am not mentally capable at the time to provide my own consent.

Signature:_____

Signed this _____ **day of** _____, _____.
(day) (month) (year)

2. If the person named on page 1 of this form is not capable of consenting to the directions given in this form, then signatures from a health care provider and the substitute decision-maker are required below.

(a) I have discussed the person's condition, the person's wishes and the treatment options with the individual or the individual's substitute decision-maker. I believe that the directions contained in this form are medically appropriate.

Name of Physician or Registered Nurse: _____
(please print)

Signature of Physician or Registered Nurse: _____

Signed this _____ **day of** _____, _____.
(day) (month) (year)

(b) I have discussed the above person's condition with the physician and/or registered nurse and understand the information and options provided. The above directions reflect the person's wishes, or, if the wishes are not known, they reflect the values and beliefs of the person, or, if these are not known, are in the best interests of the person.

Name of Substitute Decision-Maker: _____
(please print)

Signature of Substitute Decision-Maker: _____

Relationship to Person:_____

Signed this _____ **day of** _____, _____.
(day) (month) (year)

Contact Information for Substitute Decision-Maker: _____
(phone number)

_____
(address)

Please provide Original to Patient/Substitute D-M, Copy to Physician or Nurse and Copy to Facility for placement on chart (where appropriate)

Information on this form is being collected pursuant to the *Care Consent Act* to set out the wishes and/or substitute consent for care. For more information, contact the Health and Social Services ATIPP Coordinator (H-1), Box 2703, Whitehorse Yukon, Y1A 2C6, (867) 667-5919.