*(Date) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

To whom it may concern *(for example emergency staff and ambulance officers)*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Re:***(Name of patient, address, date of birth) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Name of patient)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_has *(type of life limiting condition) \_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_*\_\_.*

 **In view of (*name of patient)*’s overall prognosis, CPR/Intubation/ intensive care should not be attempted if his/her condition deteriorated, as this would be highly unlikely to be successful and would be inappropriately burdensome.**

This has been discussed with *(name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,* and his/her *(spouse/other caregiver etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* and 'person responsible' *(name of person(s))\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_,* and they agree that CPR/intubation/intensive care should not be attempted. If*(name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* were to become critically unwell, s/he would wish to be allowed to die naturally and to have full comfort care. *(Name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* has requested that I write this letter to document his/her wishes.

*(Name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* is receiving palliative chemotherapy, so transfer to an acute care facility may still be appropriate at this stage, for example to administer intravenous antibiotics and fluids, if indicated.
**OR**
*(Name of patient)\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* would prefer to remain at home as long as possible and if feasible to die at home.

**OR**

*(Name of patient)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* would prefer to avoid readmission to the acute hospital. If s/he develops symptoms that are not able to be managed at home then s/he could be (re)admitted to (*name of* *palliative care unit or alternative place of care )\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*

*(Name of patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*and/or their family have discussed these issues with *(name of clinician) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.*

For any further information about this patient please contact *(GP and/or palliative care service contact information)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Yours sincerely

*(Signature here) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(Name and designation) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Copies to:*

Patient
GP
Community Palliative Care Team
Other specialists involved in the patients care
Home Nurses if applicable

*From: HammondCare Palliative Care Service, North Sydney*