Think ahead

Speak for Yourself

MY FORM

Name: _____

THINK | TALK | TELL | RECORD | REVIEW

Think ahead
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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 who are well. It aims to guide you in thinking about, discussing, and recording your preferences regarding all aspects of end of life.

It encourages you to ensure that those closest to you are aware of these preferences so that, should a time come when you are unable to express them yourself, 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 etc.) and who you would like contacted in the event of an emergency. If you do wish to fill out the entire form, we encourage you not to fill it all out at once. Instead, take your time and complete it over several sittings.

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 clinicians will not know your wishes, and disagreements may occur. YOU can provide guidance by 'Thinking Ahead' and Section 2 of this form focuses on your medical care preferences.

Your GP or treating doctor will obviously be central to your care. We encourage you to discuss your care preferences with them. However, in an emergency situation, the doctor treating you may be completely unfamiliar with you, or your care preferences. In those situations, an express 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. Regular updating of your wishes is important if they are to be useful in the event of a medical emergency or life limiting illness. For that reason, we encourage you to view this form as a living 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.

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CONTENTS

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

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SECTION 1. KEY INFORMATION
In Case of Emergency (I.C.E)

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:

Common or Nickname:

I would prefer to be called by my:

First Name	Surname	Common or Nickname
☐	☐	☐

Address:

Phone Numbers:

Gender:

Date of Birth:

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. It is very important that you discuss this with these people, letting them know that you are naming them as your emergency contacts.

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:
(Featured on front of card)

_____

Private Health Insurance

Do you have private Insurance?

Yes ☐ **No** ☐

Name on Policy:

_____

Name of Insurance Company:

_____

Policy Number:

_____

REVIEWS

Signature: _____	Date Reviewed: _____
Signature: _____	Date Reviewed: _____
Signature: _____	Date Reviewed: _____
Signature: _____	Date Reviewed: _____

Think ahead
Speak for Yourself

MEDICATIONS

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

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Speak for Yourself

SECTION 2. CARE PREFERENCES

This section provides key information about you that can be used to inform your 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 preferences or religious beliefs that you would like the healthcare staff to consider in caring for you?**

These are important questions and 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 contains three separate sections.

1. The first deals with your care preferences in the event that you become ill and cannot speak for yourself.

2. The second 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 speak for yourself. It also allows you to nominate someone, called a ***Patient-Designated Healthcare Representative****, who can speak on your behalf. Advance Healthcare Directives are recognized in the courts, and will soon be provided for in Irish legislation. If you have appointed an attorney 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

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 may be unconscious, or you may be conscious but unable to understand such information due to cognitive impairment/confusion or may simply lack capacity to make decisions. With this in mind:

Would you like a relative or friend 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**

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Speak for Yourself

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

Name: **Relationship:**

Phone: **Email:**

Care Preferences

If it is determined that 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 preferences/Religious beliefs

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

Keep in Mind

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 possible or available.

Think ahead
Speak for Yourself

Other wishes

Thinking 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.

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

_____

Name of preferred Hospital/Hospice/Nursing Home:

_____

_____

_____

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 possible or available.

Is there anything in particular you would or would not like in your final days of life? (e.g. photos, favourite music, rituals, prayers etc.) 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 an adult with capacity (the ability to understand and process information in order to make a decision) setting out his/her preferences about medical treatments they **do not want** to receive in the future, in case a time comes where they lose capacity or cannot speak for themselves. You cannot demand particular treatments in an Advance Healthcare Directive, but you can refuse medical treatment – even if this refusal is considered by some to be unwise, or may result in your death.

Advance Healthcare Directives are recognized in Irish courts. They will soon be provided for in legislation. They are legally binding, which means that if a valid AHD exists, treating doctors are legally bound to follow them. They can be revoked orally or in writing. They can also be altered at any time, but any alteration must be in writing and must be witnessed in the same way as the original. This section is written in light of the draft heads of the legislation which are currently available. It will be amended as appropriate once the legislation has been enacted.

An AHD also allows you to nominate a Patient Designated Healthcare Representative. This is someone who will be allowed to speak for you if you are unable to speak for yourself. They can have as much authority as you decide to give them, up to and including the power to consent to/refuse life-sustaining treatment on your behalf.

There is no obligation to make an Advance Healthcare Directive. It is completely your decision. This section simply provides you with a space to record any 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 speak for yourself.

Name: _____ **Date of Birth:** _____

Address _____

Name, address, and contact details of your GP or other healthcare professional

_____

Does this Advance Healthcare Directive contain a refusal of life sustaining treatment?

Yes ☐ **No** ☐

Have you created an ***Enduring Power of Attorney*?***

Yes ☐ **No** ☐

If yes, please give contact details for person(s) appointed as attorney(s).

_____

_____

Have you given your attorney authority to make healthcare decisions on your behalf?

Yes ☐ **No** ☐

If yes, have you given your attorney authority to refuse life sustaining treatment on your behalf?

Yes ☐ **No** ☐

* See Glossary

Patient-Physician Partnership

We strongly recommend that you speak to your GP or primary medical professional before completing this section of the form. He or she may be the person best placed to give you the information you need before deciding about the care and treatment you would like.

Patient-Designated Healthcare Representative

This section allows you to appoint a Patient-Designated Healthcare Representative if you wish. This person may be a trusted family member or a close friend, and will be able to speak for you if you are unable to speak for yourself. Therefore it is important to speak to him or her regarding your wishes. **You do not have to appoint a representative and can merely set out your wishes in an Advance Healthcare Directive.**

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.

Your Patient-Designated Healthcare Representative

Name:

Relationship:

Address:

Phone:

Email:

Alternate Patient-Designated Healthcare Representative

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

Name:

Relationship:

Address:

Phone:

Email:

Note: Currently, if you specify who you want to act on your behalf this will be respected. Legislation which will provide for the formal recognition of your right to appoint a representative is due to be enacted over the coming months. In this section we have used the terminology used in the proposed legislation.

I have given my Patient-Designated Healthcare Representative the following authority:

- ☐ Power to ensure that the wishes I have expressed in this Advance Healthcare Directive are carried out.
- ☐ Power to consent to or refuse medical treatment on my behalf, apart from life-sustaining treatment.
- ☐ Power to consent to or refuse medical treatment on my behalf, up to and including life-sustaining treatment.

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 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 place 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)

OR

☐ I **do not** want life sustaining treatments at all. If life sustaining treatment has commenced, I request that it be discontinued. I understand that this will result in my death

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, 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 want to receive, please mention these below.

*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.

* See Glossary

Think ahead
Speak for Yourself

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. E.g. If I am diagnosed with terminal cancer, I do not wish to receive chemotherapy.

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 preferably should not be your attorney or patient-designated healthcare representative.

Your Signature	Date
Witness 1 Signature	Date
Witness 2 Signature	Date

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 alleviate any suffering.

Think ahead
Speak for Yourself

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 Patient-Designated Healthcare Representative: Yes ☐ No ☐

Contact details: _____

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

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: _____

Think ahead
Speak for Yourself

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.**

  OR

- ☐ **I do NOT want life-sustaining treatments at all. If life sustaining treatment has started, I request that it be stopped, even though this will result in my death.**

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

Any other 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: _____

* See Glossary

Think ahead
Speak for Yourself

SECTION 3. LEGAL

PRIVATE

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

3.1 Legal

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.

_____

_____

_____

Have you appointed an attorney 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)

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, he/she/they have limited authority. Please specify what areas of your affairs they have authority for

☐ No, he/she/they have general authority for my estate, finances personal care and healthcare.

_____

_____

Have you given your attorney(s) authority to refuse life-sustaining treatment on your behalf?

Yes ☐ **No** ☐

It is necessary for a solicitor and medical practitioner to certify that you are freely making an Enduring Power of Attorney and understand the implications of doing so.

** See Glossary*

Need Help?

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

Think ahead
Speak for Yourself

SECTION 4. FINANCIAL

PRIVATE

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 be unable to do so. For more information about this, please **www.thinkahead.ie**

In order to make it easier for your family/attorney or executors to assist you in the event that you lack capacity, and to arrange your affairs after your death, please provide the following where relevant to you:

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**

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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.

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Speak for Yourself

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

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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: Whether or not you would like a *post mortem to be carried out, 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.

Although you may express a preference to become an organ donor, written consent from your next of kin will also be required at the time of a potential donation.

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.

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)

_____

Note: You cannot volunteer to donate your body to medical science if you have already elected to donate your organs. This means that you should not complete both section 5.1 and section 5.2

** See Glossary*

Need Help?

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

Think ahead
Speak for Yourself

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.

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. 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 family of a deceased person, or the deceased person's doctor, may request that a post-mortem be carried out. This is what is called a hospital post-mortem. Where a doctor has a requested a post-mortem, consent of next of kin must be obtained.

If, upon my death, a hospital post-mortem is requested by a healthcare professional, my family should consent to this:

Agree ☐ **Disagree** ☐

Think ahead
Speak for Yourself

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 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:

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My preferred funeral director is:

Name:

Phone:

Address:

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

Please specify the location of the grave papers below:

I wish to be: Please Circle

A) Buried

B) Cremated

Preferred cemetery or crematorium:

I would like my ashes to be scattered in the following location(s):

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:

Speak for Yourself

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:

Think ahead
Speak for Yourself

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	
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

List below:

_____

_____

_____

_____

_____

4. Pets

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

List below:

_____

_____

_____

_____

_____

Think ahead
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GLOSSARY

Advance Healthcare Directive	A written statement made by a person with capacity, setting out his/her will and preferences about medical treatments that may arise in the future, at a time when they no longer have capacity and so cannot make decisions.
Attorney	The name given to a person 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.
Basic Care	This includes, but is not limited to, warmth, shelter, oral nutrition and oral hydration and hygiene measures.
Capacity	The ability to understand the nature and consequences of a decision, in the context of the choices available, at the time the decision has to be made.
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.
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	This is a legal document which a person can create while they have capacity, in which they can appoint another person to act on their behalf if a time comes when they no longer have capacity to make decisions.
Executor(s)	This is a person(s) named in a Will that will have responsibility for making sure the instructions contained in the Will are carried out.
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 monthly 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.
Patient-Designated Healthcare Representative	A person you may choose to nominate in an Advance Healthcare Directive. This person will have authority to speak for you regarding healthcare decisions if you lose capacity and cannot speak for yourself.
PEG tube feeding	Percutaneous endoscopic gastrostomy. This is a method of artificial feeding in which a tube is passed into a patient's stomach.
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 wishes for how your property/possessions should be distributed upon your death.

Think ahead

Speak for Yourself

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