

This Emergency Health Care Plan (EHCP) includes recommendations for treatment, based on my wishes and preferences in the event of an emergency.



Full Name: _____ NHS no: _____

Date of Birth: _____

Where was this form completed? (e.g. home, hospital): _____

My emergency contacts

Name _____ Relationship _____ Tel. _____

Name _____ Relationship _____ Tel. _____

Have you given anyone Lasting Power of Attorney (LPA) for your Health & Welfare?

Yes, and their details are below. No, I have not given anyone this

The attorney is the person, or people named on your **LPA for Health and Welfare document**, who can help make decisions for you if you can't. (Leave this blank if you ticked 'No').

Attorney name(s) _____ Tel. _____

For children and young people, who has parental/guardianship responsibility?

I was able to participate in making the decisions around this plan

Yes No

If no, please detail reason and details of family/legal/welfare proxy below

Names, roles and relationships of individuals involved in these discussions:

My health problems and current condition

What I understand about my health and current condition including my diagnosis/ diagnoses and personal circumstances:

My preferred place of care is _____

My preferred place of death is _____

Name of Individual:

NHS Number:

This Emergency Health Care Plan (EHCP) includes recommendations for treatment, based on my wishes and preferences in the event of an emergency.

This section is to be completed by a healthcare professional with the involvement of the patient and/or carer.

In the event of...

What to do...

Possible emergency and a description of what will be observed

Please try to separate your advice to include advice for patients, families/carers and all other services e.g. GP or emergency services, so that it is easy to follow.

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Name of Individual: NHS Number: **Other services and professionals involved in my care**

Service/Person's Name	In-Hours Tel.	Out-of-Hours Tel.	Aware key contact?	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Details of other relevant care planning documents and where to find them

Select the documents believed to be already in place:

- Do not attempt cardiopulmonary resuscitation (DNACPR)
 Advance Decision to Refuse Treatment (ADRT)
 Advance Statement (AS)
 Treatment Escalation Plan (TEP)

Where to find these: **Additional Information**

If required, please use this space to write any additional information that will inform the clinical team

Review of EHCP (Periodic reviews can help confirm this plan remains current)

Date of Review	Name of Reviewer	Signature of Reviewer
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

If a new EHCP is written the previous EHCP should be crossed out and marked as 'invalid'. If there are any doubts about the content of the EHCP there should be a discussion between the individual (if they have capacity), parents/carers and the most appropriate senior available clinician at the time of the emergency to ensure that the EHCP still reflects the individual's best interests and current management plan.

Discuss / share the information from this EHCP with all key services in and out of hours (e.g. Ambulance Service, OOH GP, etc.)

This form is valid when signed. (The authorised healthcare professional is defined by local policy). Digital signatures are permitted.

This is an advisory form which does not expire but should be reviewed at available opportunities, whenever this person's condition or situation changes, or at this person's/clinician's request.

HEALTHCARE PROFESSIONALProfessional Signature Date Name (print) Role Registration N^o