This is an advisory form and is NOT legally binding. It does not replace a DNACPR, TEP, AS or ADRT

EHCP

This Emergency Health Care Plan (EHCP) includes recommendations for treatment, based on this individual's wishes and preferences, in the event of an emergency. The named individual must be supported to understand and participate, in line with principles of the Mental Capacity Act 2005.

EMERGENCY HEALTHCARE PLAN

Full Name: **NHS no:**

Date of Birth:

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

Emergency contacts

Name		**Relationship**		**Tel.**	
Name		**Relationship**		**Tel.**	

Has the individual given anyone Health & Welfare Lasting Power of Attorney (LPA)?

☐ **Yes**, and their details are below. ☐ **No** Health & Welfare LPA document

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

Attorney name(s) **Tel.**

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

Was this individual considered to have capacity to take part in EHCP decisions?

☐ **Yes**, no reason to doubt capacity ☐ **No**, capacity absent

If **no**, EHCP decisions **must** follow the *Mental Capacity Act 2005* Best Interests process.

Comment on capacity (MCA 2005), and on individuals and professionals involved in this EHCP:

Overview of health problems and current condition

What is important to know about this individual's health and current condition, including their diagnosis/diagnoses and personal circumstances:

Their preferred place of care is

Their preferred place of death is

Form developed by the NHS *NENC Deciding Right* group. **Ver. 16 (Print-Ready Build PDFJP04):** adapted with stakeholder input 2025-2026.

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.

EMERGENCY HEALTHCARE PLAN

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Name of Individual:		NHS Number:	

Other services and professionals involved in this individual's care

Service/Person's Name	In-Hours Tel.	Out-of-Hours Tel.	Aware key contact?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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

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. By signing, the healthcare professional records that the principles of the Mental Capacity Act 2005 have been considered and applied in preparing this document, including Best Interests decision-making where individuals lack capacity.

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 individual's/clinician's request.

HEALTHCARE PROFESSIONAL

Professional Signature	
Date	
Name (print)	
Role	
Registration Nº.	

EMERGENCY HEALTHCARE PLAN