Advance Care Planning
Conversations Worth Having

Module 1 Worksheet
Advance Care Planning or Health Care Consent

Brenda recently visited her family doctor for her routine wellness check. Dr. Ryan gave her an Ontario Speak Up workbook to take home and read. Brenda told her husband Clark he would be her automatic Substitute Decision Maker (SDM) and he needed to read the booklet too.	**ACP or HCC**
Part A: Myrna Fox is an 87 year old widow who was admitted to your long term care facility 8 months ago because her heart failure had progressed to the point where she was no longer able to walk even short distances without becoming extremely short of breath. Her only daughter Diane had to rush her to emergency 3 times before her admission with severe chest pain. At her 6 month follow up care conference with her health care team Myrna shares that if her heart stops she doesn't want any CPR.	**ACP or HCC**
Part B: While Myrna's daughter Diane is visiting on the weekend, Myrna shares how wonderful and caring the staff are to her. She lets Diane know that no matter what happens in the future she never wants to have to be taken to the hospital, she wants to stay at her long term care home until the end of her life.	**ACP or HCC**
Janice is at her oncologist's office for a follow up visit after her recent round of testing. Her doctor shares that she wishes she had some better news, but unfortunately the biopsy and scans show that she has very advanced cancer in her bowel which has spread to her liver, lungs and bones. The physician takes time to explain the treatment options available, the risks, benefits and side effects, took the time to discuss alternate courses of action as well as the consequences of not having the recommended treatment. Janice tells her doctor that she does not want to have any surgery or chemotherapy and as long as she will promise to keep her comfortable, she would like to travel while she still feels well.	**ACP or HCC**