

PATIENT MANAGEMENT SUMMARY (e.g. for ambulance personnel/other acute healthcare providers)	
Date completed:	Patient Identification Label (or write full legal name, NHI number and home address)
Patient name (prefered):	
Lead health practitioner (name/practice):	Contact number:
	After hours contact details:
Associated hospice (if applicable):	Contact phone number:
Diagnosis:	
Co-morbidities:	Allergies:
Interpreter required: Yes No Contact details:	Language:
Does the patient have an Advance Care Plan/Advance directive? Yes (see attached) No	
MEDICINE OPTIONS (include indication) – The following treatment options have been considered appropriate in consultation with the patient/EPA and/or family/whānau. See next page for further patient care goals.	
INJECTABLE MEDICINE (name only) AVAILABLE AT HOME TO BE ADMINISTERED	
ENACTED EPA (Enduring Power of Attorney) Yes] No
Name:	Contact number:
Relationship to patient:	
Name and signature of health practitioner completing form:	
Signature of patient/EPA if appropriate:	Date



PATIENT GOALS OF CARE

What do we need to know about you to provide the best care?	
Care advice already discussed with the patient/EPA and/or family/whānau:	
(e.g. current medicine use, non-pharmacological advice for providing comfort and what to avoid)	
Instructions provided in event of deterioration:	
(e.g. additional medicines to be administered, protocol for obtaining further assistance)	
Other wishes or preferences the patient may have:	
(e.g. cultural, spiritual or family/whānau considerations, preferences related to CPR or other medical interventions, admission to hospital/hospice or remaining at home)	
N.B. Attach any other advance directive documentation, if applicable.	
Signature of patient/EPA: Date:	
Date.	