STATEMENT OF WISHES – COVID-19	Please complete the following:
	Clinical Record No:
	SURNAME:
	Given Name:
	Date of Birth:
	Room No.: Admission Date:

This document has been developed to provide guidance for the future care and treatment of a resident who tests positive to COVID-19. The statement should be read in conjunction with the resident's existing Advance Care Directive/Plan.

PEOPLE INVOLVED IN DEVELOPING THIS STATEMENT:

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

Name: _____

Role: _____

WORRIES, WANTS AND WISHES:

1. At this time the resident/substitute decision maker are most worried about:

_____

_____

_____

Surname: Given name: CR No.

2. The resident and/or their substitute decision maker understand that the following health conditions mean that they are at an increased risk of serious illness or death from COVID-19.

3. If the resident was to test positive with COVID-19 they are worried about *(for example: how unwell could I became if tested positive with COVID-19, what treatment and care options are available, where I would be able to receive my care and treatment preferences)*

4. If the resident becomes seriously ill with COVID-19 then the following are most important to the resident: *(for example: to have contact with my family, the listen to my music, to have my cultural and spiritual practices supported, to have my symptoms managed)*

5. If the resident tested positive for COVID-19 they would want:

☐ treatment aimed at comfort and care which is consistent with their existing Advance Care Plan/Directive

☐ treatment aimed at prolonging life

NAMES AND SIGNATURES OF THOSE INVOLVED IN PREPARING THIS STATEMENT

Name resident:

Substitute decision maker:

Signature:

Date:

Name of medical practitioner:

Signature:

Date:

Once completed, file in Resident's Clinical Records.