NHS Highland Anticipatory Care Patient Alert (ACPA)

Patient's Name: Address and Post Code: Date of Birth: CHI: Telephone No.: Keypad number (if relevant):	Carer/family contact : Telephone No: Additional Keyholder: Telephone No: Named community Nurse : GP Practice: Home Care Contact: Help Call contact number (if available):
Significant Diagnoses:	Current Medication: Allergies :

What is the plan in case current condition(s) deteriorate(s)?

Are additional care plans held in the patient's home? SSA: Yes□ No□ Self Management Plan: Yes□ No□
Other (please specify): Yes□ No□

Are rescue medications kept in the house (eg steroids, antibiotics) Yes □ No □
If so, please list here :

Has the patient arranged Power of Attorney (PoA): Continuing PoA (financial/property etc)? Yes □ No □
Welfare PoA (health or personal welfare)? Yes □ No □
If PoA is not in place, has a Guardianship order been agreed through the courts? Yes □ No □
Contact details of person with Welfare PoA/Guardianship:

Have end of life choices been discussed? Yes □ No □
If a living will is in place, who holds copies?

Is the Patient suitable for FAST Protocol if suspected stroke/CVA? Yes □ No □

Has Resuscitation been discussed with the patient Yes □ No □ and Family Yes □ No □
Is resuscitation appropriate? Yes □ No □
Has Do Not Resuscitate been agreed? Yes □ No □ If Yes, has DNACPR form been faxed to Hub Yes □ No □

What is the plan should the main carer fall sick?

What is the Preferred Place of Care?

If hospital admission is necessary, which hospital should be first choice?

I have read the above information and give my consent for this information, and any updates, to be shared within the Highland Out of Hours Service and other Health or Social Care Professionals.

Patient Name: Patient Signature: Date:

Health Professional Name: Health Professional Signature: Date:

If the patient is unable to sign this, have they otherwise given their witnessed consent Yes □ No □
If the patient is unable to give consent, has the Adults with Incapacity Act form been completed Yes □ No □

For Official Use Only:

Adastra Signature of GP: ………………………………………………. Date information uploaded/amended: ………………………	Method of Identification of Patient *(for payment purposes)*: Care Home Resident Yes □ No □

Please ensure information from form is input onto ADASTRA system and changes at Reviews made on the system.