My Advance Care Plan

This Advance Care Plan Belongs To: _____

I have reviewed and updated **My Advance Care Plan** on the following dates:		

Interior Health

810375 Aug 14-25

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Land Acknowledgement

Interior Health recognizes and acknowledges the traditional, ancestral, and unceded territories of the Dãkelh Dené, Ktunaxa, Nlaka'pamux, Secwépemc, St'át'imc, syilx, and Tŝilhqot'in Nations where we live, learn, grow, collaborate and work together.

What is Advance Care Planning?

Advance care planning (ACP) starts with you; it is about thinking ahead, discussing and writing down what's important to you so your loved ones and health care team can know your values and wishes if you are unable to speak for yourself. It can begin at any stage of life and can be revisited throughout your life journey.

My Advance Care Plan Workbook Instructions

This **My Advance Care Plan** workbook is yours; it will guide you through the 5 steps of ACP with prompting questions to assist you in completing your own advance care plan.

Take your time going through the workbook; it does not need to be completed all at once. You may have questions and want to talk with others or seek some advice before completing a specific step. Remember, the information you write today, can be changed as your life circumstances change.

Share a copy, or portions of this workbook, and/or its location with a trusted loved one, ideally your Substitute Decision Maker, also known as your Representative, (see pages 10 & 11), and/or your health care provider (e.g. doctor, nurse, social worker). You can also print out and store your **My Advance Care Plan Summary**, found on pages 20 & 21, in your Greensleeve (see page 17 to learn more).

Please download this workbook and save it to your computer before you type in your answers. This workbook is also available in hardcopy. You can request one by contacting your local Home and Community Care office.

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5 Steps of Advance Care Planning

The following 5 steps are part of Canada's national ACP framework to guide people through the process.

THINK about your values, beliefs, wishes and goals of care.

LEARN about your health, medical care options and the role of a Substitute Decision Maker (SDM) and Temporary Substitute Decision Maker (TSDM).

DECIDE what health care you want to accept or refuse, and who will be your SDM.

TALK about your wishes with your loved ones, SDM and health care providers.

RECORD your wishes by writing them down in this workbook. Keep all your ACP documents together and let your SDM know where they can be found. This recorded information becomes your Advance Care Plan.

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Common ACP Documents in British Columbia

Below is a list of important definitions related to ACP in the province of B.C. It is recommended to seek legal advice to review the unique authority of each document and ensure all legal requirements are met.

Advance Care Plan: A document(s) that records your specific personal and health care wishes and instructions.

Advance Directive: A legally binding document that states what health care you give consent or refusal to, in advance.

Enduring Power of Attorney: A legal document in which you appoint one or more persons to handle your financial and legal affairs. It is valid while you are capable to make your own decisions and remains valid if you become unable to make your own decisions.

Medical Orders for Scope of Treatment (MOST): A MOST is a medical order, completed by your physician or nurse practitioner, to let your health care team know what level of care you wish to receive. Each Health Authority in B.C. has their own MOST form.

Representation Agreement Section 7 (Rep 7): A legal document in which you appoint a representative (SDM) to help make decisions on your behalf regarding personal care, health care, and may also include routine management of financial and legal affairs.

Representation Agreement Section 9 (Rep 9): A legal document in which you appoint a representative (SDM) to help make decisions on your behalf regarding personal care and health care, including living arrangements, participation in activities, and giving or refusing consent to life-preserving health care.

Substitute Decision Maker(s) (SDM): A person(s) you legally appoint to make health care decisions on your behalf if you are not capable to make your own decisions.

Temporary Substitute Decision Maker (TSDM): A person chosen by the health care team, from an ordered list determined by B.C. law, to make health care decisions on your behalf if you are not capable to make your own decisions and you have not completed a Rep 7 or Rep 9, or your SDM is not available.

Will: A Will is a legal document that provides direction on what to do with your property and belongings, any care needs of dependents, e.g. minor children, pets, and other wishes for after you die.

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ACP Is For Everyone Graphic

The enclosed graphic represents the ACP process and possible stages of a person's health journey. The nautical theme reflects the beautiful and unique nature of British Columbia with each wave representing progressive changes in a person's health condition: *Thinking Ahead, Health Event, Chronic Illness or Injury Progression, Advancing Illness, and End of Life*.

The ebb and flow of water can be reflective of one's own health journey, as well as their comfort with embracing aspects of ACP. The waves have various icons that speak to one of the recurring **5 Steps of ACP: Think, Learn, Decide, Talk and Record**.

Reflecting Questions...

Here are some questions to consider as you explore ACP through the various waves and identify where you currently imagine yourself being on the graphic.

ACP Is For Everyone: Are you like the people on the shore who are just starting to think about ACP? Have you ever had a conversation with someone about ACP?

Thinking Ahead: What makes your life meaningful? How would your beliefs and values impact your health care decisions? Have you written these down? Do you know what legal forms would be needed to communicate your wishes if you couldn't speak for yourself?

Health Event: If you received a new diagnosis or had a serious injury, who would you talk with to learn more? Who would you trust to be your Substitute Decision Maker (SDM) and speak on your behalf? Have you recorded your goals of care?

Chronic Illness or Injury Progression: Have you noticed changes in your health? Have you spoken with your health care provider about them? Do these changes impact previous ACP decisions you've made? If so, have you talked with your SDM and loved ones about these decisions?

Advancing Illness: With advancing illness, have your health goals and priorities changed? Have you shared these with your SDM? Does your Advance Care Plan or Advance Directive need to be updated? Have you spoken with your health care provider about MOST? Would you want all available care to prolong your life?

End of Life: What does a good death mean to you? When you think about dying are there things you worry about? If you were nearing death, what would you want to make things most peaceful for you? Do you have any spiritual, cultural or religious beliefs that would affect your care at the end of life?

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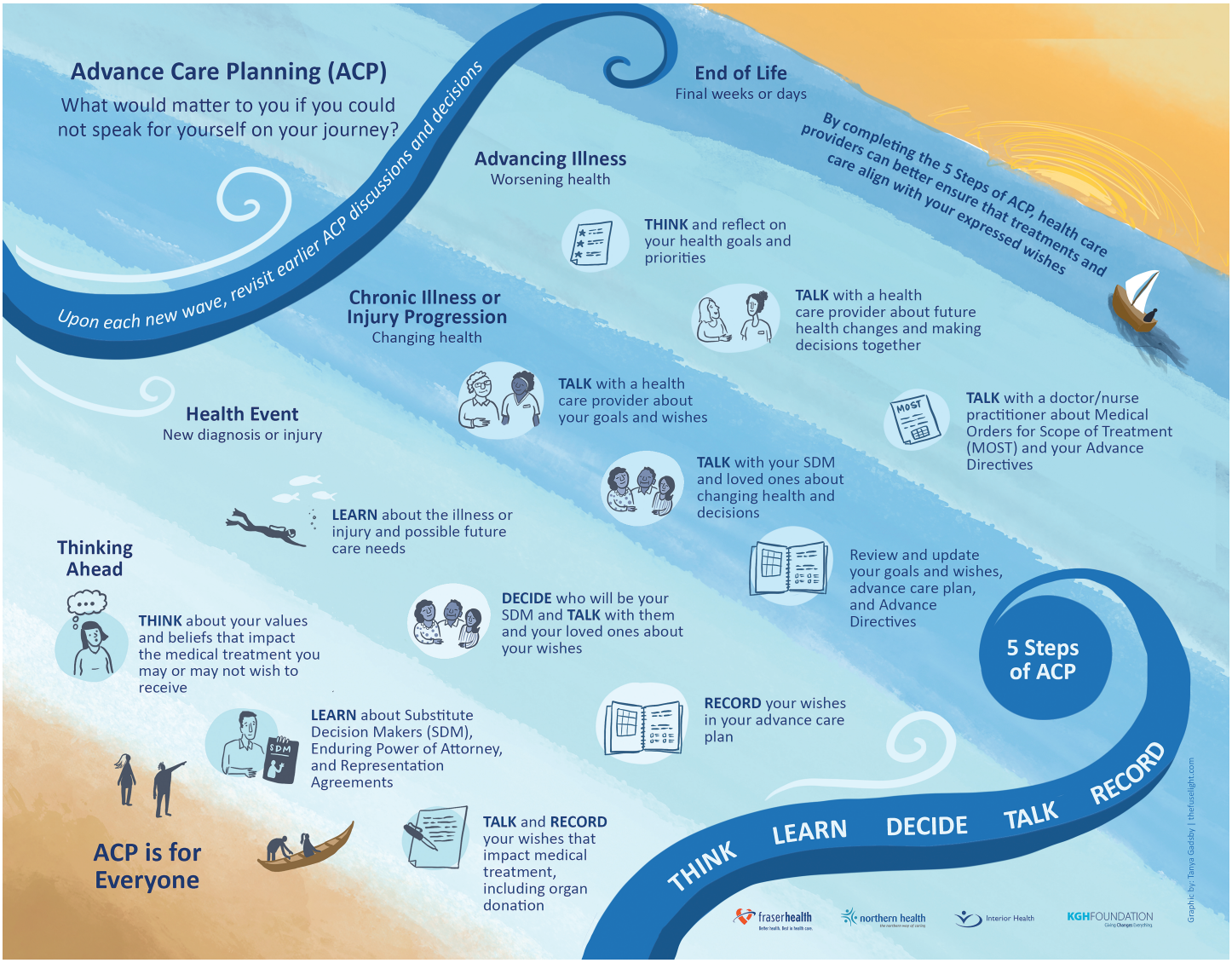

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Step 1: **Think**

Thinking about what is important to you can help you make decisions related to your health. Think about your values, beliefs, wishes and what type of care you may or may not want to receive. Taking time to identify what matters most to you can help guide and understand your feelings, behaviours and choices.

What makes my life meaningful?

Values are based on our personal ethics and/or ideals that help guide our decision-making process. Some values influence our lives more than others. A core value is a belief or personal priority so deeply held that it would cause you to make a life-changing decision. Select your top five core values or fill in your own. Some of the unselected values may still be very important to you, but they may not be a core value that guides all you do.

- ☐ Authenticity
- ☐ Autonomy
- ☐ Balance
- ☐ Compassion
- ☐ Community
- ☐ Courage
- ☐ Fairness
- ☐ Faith
- ☐ Family
- ☐ Friendships
- ☐ Fun
- ☐ Growth
- ☐ Happiness
- ☐ Honesty
- ☐ Humour
- ☐ Inner Harmony
- ☐ Integrity
- ☐ Kindness
- ☐ Knowledge
- ☐ Love
- ☐ Loyalty
- ☐ Openness
- ☐ Optimism
- ☐ Recognition
- ☐ Religion
- ☐ Reputation
- ☐ Respect
- ☐ Spirituality
- ☐ Stability
- ☐ Trust
- ☐ _____
- ☐ _____
- ☐ _____

Three things I hope to see and do in my lifetime:

1. _____
2. _____
3. _____

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I would find certain health situations difficult to live with, e.g. loss of memory, constant pain, not being able to speak, being bedridden, etc.

To me, “quality of life” means...

If I were nearing death, what would I want to make the end more peaceful for me? (e.g. location, chosen family, friends or pets nearby, music, spiritual practices, etc.)

Think about who you would trust to make decisions on your behalf if you couldn’t speak for yourself. Think about how you would like to approach this topic.

Ask yourself, ‘Who knows me really well? Who can I talk with about what matters most to me and my health care wishes?” See page 11 for more information on Substitute Decision Makers.

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Step 2: **Learn**

Learn about your health, medical care options and the role of a Substitute Decision Maker (SDM). Planning early gives you the time you need to carefully identify your choices, needs and preferences, as well as time to complete important legal documents.

Please watch Interior Health's Advance Care Planning: Your Voice, Your Choice *video series on YouTube.*

What are my current health concerns and questions?

Regarding my condition and treatment, I'd like to know (select a circle along the scale)...

○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○

Only the basics — All the details

I have a current MOST (Medical Orders for Scope of Treatment)

○ Yes ○ No ○ Don't Know ☐ I need to learn more about MOST

Note: You can request a printed copy of your MOST form for your records from your health care team

I would like to learn about the following medical interventions: (check all that apply)

- ☐ CPR (Cardio-pulmonary resuscitation)
- ☐ Tube feeding
- ☐ Intubation
- ☐ Defibrillation
- ☐ Life support machines
- ☐ Organ transplant/donation
- ☐ Blood transfusion
- ☐ Artificial hydration and nutrition
- ☐ Dialysis
- ☐ _____

I need to learn about: (check all that apply)

- ☐ MOST/Goals of Care
- ☐ Advance Directive
- ☐ Substitute Decision Makers
- ☐ Representation Agreement section 9
- ☐ Representation Agreement section 7
- ☐ Enduring Power of Attorney
- ☐ A Will
- ☐ _____

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Representation Agreement Information

Below is an explanation related to the two types of Representation Agreements.

If you are working with a lawyer to complete your will and /or other advance care planning documents, they will provide the necessary forms.

If you are completing your Representation Agreement on your own, be sure to research the forms listed below to ensure your Representation Agreement meets legal requirements. You can also ask your health care provider to locate these documents online and print copies for you.

Representation Agreement (Section 9)

Use a section 9 form if you want your representative (SDM) to be authorized to make decisions about accepting or refusing life support and life prolonging medical interventions on your behalf, in addition to other health and personal care decisions.

Click here to download a Rep 9 Agreement

Representation Agreement (Section 7)

Use a section 7 form if you want your representative (SDM) to be authorized to make decisions about your routine financial affairs, your personal care and some health decisions.

A section 7 form does not provide a representative (SDM) with the authority to refuse life support or life-prolonging medical interventions.

In addition to a section 7 Representation Agreement form, the following certificates must be completed (if they apply) for the agreement to be effective:

Form 1: Certificate of Representative or Alternate Representative

Form 2: Certificate of Monitor

Form 3: Certificate of Person Signing for the Adult

Form 4: Certificate of Witnesses

Click here to download a Rep 7 Agreement

Please note that each province in Canada has its own legislation and forms that guide advance care planning.

Even if you have appointed an SDM it is advisable to complete the ***My Temporary Substitute Decision Maker (TSDM) List*** *(see page 11) to ensure contact information is available for the health care team. A TSDM must be 19 years or older, be able to understand and make an informed decision, have no dispute with you, and have been in contact with you in the past year.*

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Selecting A Substitute Decision Maker for Your Representation Agreement

If you cannot speak for yourself, your SDM will make decisions for your care. For this reason, it is very important you carefully select your SDM. This individual will have the authority to make decisions on your behalf regarding personal care, health care and, if you complete a Rep 7, also routine financial and legal matters.

You are encouraged to reflect on the following questions before selecting your SDM:

- Are they willing and able to make hard decisions during stressful times?
- Will they honour you and follow your wishes even if they don't agree?
- Do they understand your wishes, values and beliefs?
- Do they understand your care needs?
- Will they ask questions and advocate for you?

Note: It's best to speak with a lawyer to obtain legal advice on the authority of SDMs.

My Temporary Substitute Decision Maker List

	Name	Phone
Spouse		
Adult Children (birth order does not matter)		
Parents		
Siblings (birth order does not matter)		
Grandparents		
Grandchildren		
Anyone else related to me by birth or adoption		
Close Friends		
Person(s) related by marriage		

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Step 3: **Decide**

Decide what health care you may want to accept or refuse, and who you would choose to speak for you if you couldn't speak for yourself.

How do I usually make health care decisions?

☐ By myself ☐ With others ☐ Others decide for me ☐ _____

When it comes to sharing information about my health with others... (select a circle along the scale)

○ · · · · · ○ · · · · · ○ · · · · · ○ · · · · · ○

I don't want those close to me to know all the details about my health

I am comfortable with those close to me knowing all the details about my health

If I am diagnosed with a serious illness that could shorten my life, I would prefer...

○ · · · · · ○ · · · · · ○ · · · · · ○ · · · · · ○

Not to know how quickly it is progressing or the best estimation for how long I have to live

To understand how quickly it is progressing and the best estimation for how long I have to live

If I was seriously ill or near the end of my life, how much medical treatment would I feel was right for me?

○ · · · · · ○ · · · · · ○ · · · · · ○ · · · · · ○

I would want to try every available treatment to extend my life, even if it's uncomfortable

I would not want to try treatments that impact my quality of life in order to extend my life

Here are my reflections about medical interventions I may or may not want (consider the interventions listed in Step 2).

If I couldn't speak for myself, I would want the people I trust to follow all my wishes or do what they think is best in the moment based on the information available at the time.

○ · · · · · ○ · · · · · ○ · · · · · ○ · · · · · ○

I want them to do exactly what I've said, even if it makes them uncomfortable

I want them to do what they believe is best for me, even if it's different from what I've said

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Where would I prefer to be toward the end of life?

○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○ · · · · · · · · · · · · · · ○

I strongly prefer to spend my last few weeks or days in a hospice or hospice-like environment

I strongly prefer to spend my last few weeks or days at home

After my death I want to be:

☐ Cremated ☐ Buried ☐ I would like my remains to be placed: _____

I have made the following decision regarding organ donation:

☐ Yes, I am a registered organ donor
☐ No, I do not want to donate my organs
☐ I need more information to make a decision.

BC Transplant (http://www.transplant.bc.ca/)

What does it mean to Be Capable?

In British Columbia, every adult is considered capable of making decisions regarding their personal care, health care, legal and financial matters unless it's demonstrated otherwise. Just because someone is not capable of making a decision in one area does not mean they are incapable of all areas. Capability is determined for each specific decision.

Being capable to make health care decisions means you understand:

1. the information about your condition for which the health care is proposed,
2. the nature of the proposed health care,
3. the risks, benefits, and alternatives of the proposed health care, and
4. that the information applies to your situation.

If it is determined by the health care team that you are incapable of making a specific decision, that is when a SDM or a TSDM would make the decision on your behalf.

For more information on capability, speak with your health care team.

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Step 4: **Talk**

As shown in the ground-breaking Advance Care Planning Video Love is Not Enough, we can't assume that our loved ones know what matters most to us if we don't talk with them about it.

Having early, important conversations with loved ones and health care providers helps them make the right decisions for you if you are unable to speak for yourself. These conversations can help you feel less anxious and more in control of your health and well-being.

These are not one-time only conversations. As your health, wishes and life circumstances may change over time it is important to keep talking! As you prepare to have these conversations here are a few tips for getting started.

When talking with a loved one, choose a time that won't feel rushed or be interrupted. Select a place that is comfortable for you; it may be at the kitchen table, at a restaurant or during a walk.

Here are a few tips to help you prepare for the conversation:

- You don't have to talk about everything or talk to everyone in the first conversation. In fact, we suggest you keep talking over time!
- Be patient. Some people are nervous or may need time to get ready to talk.
- You don't have to lead the whole conversation; it's important to also listen to what the other person says so they can ask questions and you can build trust and understanding.
- You can always change your mind as life's circumstances change over time.
- You may find out during these conversations that you and your loved ones disagree. It is natural to have some disagreement and is important to know ahead of time so that you can be clear about your wishes.

When talking with a health care provider, ask for an extended appointment so there is enough time to discuss your advance care plan. You may find it useful to come to the appointment with a list of questions that will help inform your decisions. You may need to schedule more than one appointment with your health care provider.

What questions do I have for my health care provider?

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Here are a few conversation starters that the organization Advance Care Planning Canada has suggested:

Be Straight Forward: I need your help with something...

Knowledge Share: I was at a workshop today and I would like to share what I learned.

Reflection: I was thinking about what happened to _____ and it made me realize...

Proactive Planning: Right now, I'm healthy, but I want to think ahead and be prepared if something unexpected should happen... and how we might want to handle that situation.

What Matters Most: I think it's important that people who matter to me know what's important to me about my health care and my quality of life.

In The Moment: Right now. I'm living with _____ illness, and I expect _____ . Is this what you understand too?

Clarification: I want to make sure you understand so you can honour my wishes if needed.

Thinking Ahead: I want you to be prepared if you had to make decisions on my behalf.

Who do I want to talk with about **My Advance Care Plan**? Who needs to know what matters to me regarding my health care? Check all that apply:

- ☐ Parent(s)
- ☐ Spouse/partner
- ☐ Chosen family member(s)
- ☐ Adult child/children
- ☐ Faith leader (minister, priest, rabbi, imam, etc.)
- ☐ Trusted friend(s)
- ☐ Doctor(s)
- ☐ Nurse practitioner/nurse(s)
- ☐ Social worker
- ☐ _____

What are the most important things I want to share during my conversations?

Here is a list of some other things you may want to talk about.

- Do you have any worries about your health?
- What do you need to address to feel more prepared (e.g. finances, property, legal documents, relationships, living arrangements, social media accounts, etc.)?
- Do you have any fears, concerns, or mistrust about where or how you receive health care?
- Who do you want (or not want) to be involved in your health care?
- When you look ahead to the future, are there important events or dates you hope to be present for?

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Step 5: **Record**

This step highlights the importance of recording your thoughts, reflections and decisions. Take a moment to congratulate yourself on working to complete your own **My Advance Care Plan**!

Remember to share all, or portions, of your **My Advance Care Plan** with people who need to know your wishes, and/or tell them where they can find it in your home. It's important to update your **My Advance Care Plan** if your health or life circumstances change.

Use the **My Advance Care Plan Summary** (on pages 20 & 21) to record your details. This will help you, and those you have put in charge of your affairs, find key information when needed. Consider also filling in and carrying the **My Advance Care Plan Wallet Card** found on page 23 of this workbook.

Storing Your Advance Care Planning Documents

Once you have completed your advance care planning documents, it's important to store them in a secure and accessible location. You might choose to place certain healthcare related documents in a Greensleeve (see below) and store it on, or near, your refrigerator. Not all documents will fit or need to be stored in the Greensleeve. Here are some recommended places to consider storing ACP documents:

1. **Safe or Fireproof Box:** Protect from fire, water damage, and theft.
2. **Filing Cabinet/Drawer:** Organize them in a clearly labeled folder so they are easy to locate when needed.
3. **Digital Storage:** Scan your documents and store them digitally on a secure, password-protected computer or cloud storage service.
4. **Healthcare Provider:** Provide copies of your healthcare related documents to your primary healthcare provider and any specialists involved in your care.

Share the location of your documents with your SDM and/or trusted individuals. They should know where to find these documents and how to access them (keys or passwords) in case of an emergency.

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What is a Greensleeve?

A Greensleeve is a green, plastic folder that can hold your important Advance Care Planning documents. It is best to keep your Greensleeve on, or near, your refrigerator as this is where paramedics are trained to look if they are called to an emergency. The Greensleeve is meant to be taken with you to clinic appointments or hospital visits so that health care providers know your wishes, advance directive and / or goals of care.

You can obtain a Greensleeve by asking a health care provider at an Interior Health Home and Community Care office, or by emailing advancecareplanning@interiorhealth.ca and providing your mailing address (for residents who live within the Interior Health region).

Some important papers you may wish to keep in your Greensleeve are:

- Medication List
- Representation Agreement(s)
- Copy of your MOST (Medical Orders for Scope of Treatment)
- Advance Directive
- My Advance Care Plan Summary (see page 20 & 21)

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Changing or Cancelling Your Advance Care Plan

Your personal circumstances change over time. As long as you are capable, you can change or cancel (revoke) your advance care plan at any time. This includes representation agreements and advance directives.

It is important to regularly review and make changes to your advance care plan when you believe it is necessary. During a review, ask your SDM if they are still willing and able to make health care decisions for you. Review the wishes you wrote in your advance care plan, including any specific instructions you wrote in your representation agreement or advance directive.

Before changing or cancelling your advance care plan, be sure you have up-to-date knowledge about your current health condition and any new health care treatments available to you. The instructions below tell you what to do if you want to change and update, or cancel your advance care plan, including your representation agreement or advance directive if you made them.

1. **Changes to your advance care plan, TSDM contact list and/or beliefs, values and wishes for health care.**
   - Edit, sign and date the existing pages or fill out new ones.
   - If you did not complete a representation agreement or make an advance directive before and still do not want to, skip to 4.

2. **Changes to your representation agreement and/or advance directive.**
   You have two options:
   - Make the changes directly in your existing representation agreement or advance directive and then sign and date them in front of witnesses in the same manner as you did the originals, or
   - Create a new representation agreement or advance directive to replace the old ones and cancel your old representation agreement or old advance directive (see 3).

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3. **Cancelling an existing representation agreement or advance directive.**

   To cancel (revoke) an existing representation agreement or advance directive you must:

   - Destroy the original or make another document and express your intention to cancel the old one; and
   - Give a written notice of the cancellation (revocation) to the person named as your representative, including any alternate representative or monitor.

4. **Notification of changes.**

   After changing or cancelling your advance care plan, you should:

   - Inform your SDM, family, friends and health care providers that you have changed or cancelled your advance care plan, representation agreement and/or advance directive. Provide copies of updated documents, as needed.
   - Ask your SDM, family, friends, and health care providers to give you back the old copies of your advance care plan, representation agreement and/or advance directive, so you can destroy them.

This section has been adapted from the B.C. Ministry of Health's My Voice (2020).

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My Advance Care Plan Summary

MY PERSONAL INFORMATION:

Full Name: _____

Date of Birth (dd/mm/yyyy): _____ Personal Health Number: _____

Doctor or Nurse Practitioner: _____ Phone: _____

Emergency Contacts:

Primary: _____

Relationship: _____ Phone: _____

Alternate: _____

Relationship: _____ Phone: _____

MY HEALTH INFORMATION:

I have an **Advance Directive**: ☐ Yes ☐ No ☐ I don't know

I have a **Representation Agreement** for health care decisions: ☐ Yes – **Rep 9** or ☐ Yes – **Rep 7** ☐ No

My named **Representative/Substitute Decision Maker** is:

Name: _____ Phone: _____

I have reviewed my values, wishes and preferences with my Substitute Decision Maker and/or my family member(s): ☐ Yes ☐ No

I have a **MOST** (Medical Orders for Scope of Treatment) on file as discussed with and completed by a doctor or nurse practitioner: ☐ Yes ☐ No ☐ I don't know

I am a registered **organ donor**: ☐ Yes ☐ No ☐ I don't know

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MY LEGAL INFORMATION:

I have an **Enduring Power of Attorney(s)** for finances: ☐ Yes ☐ No

Primary: _____ Phone: _____

Alternate: _____ Phone: _____

I have a **Will**: ☐ Yes ☐ No

The location of my Will is: _____

I have appointed an **Executor** of my Will: ☐ Yes ☐ No

Name: _____ Phone: _____

I have made my **funeral** arrangements: ☐ Yes ☐ No

Funeral Home: _____ Phone: _____

My ACP documents are kept in the following places (please check all that apply):

- ☐ Greensleeve
- ☐ In-home safe
- ☐ Lawyer's office
- ☐ In-home filing cabinet
- ☐ Safety Deposit Box
- ☐ Personal computer
- ☐ _____
- ☐ _____

Additional information:

Date Completed (dd/mm/yyyy): _____

Date Reviewed (dd/mm/yyyy): _____

It is recommended that an Advance Care Plan is reviewed every year or when there is a change in personal or medical situations. If it needs to be altered or changed, we recommend you complete a new My Advance Care Plan Summary and provide copies to your substitute decision maker, primary care provider and keep a copy in your Greensleeve.

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Additional Notes

You may wish to write other thoughts or details you have regarding your advance care plan documents. You can also write any questions you may have for your health care team, lawyer, SDM etc.

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My Advance Care Plan Wallet Card

If you would like to carry your key ACP information in your wallet, you can print off this page, write in your information, cut out the card, fold and store in your wallet.

My Advance Care Plan Wallet Card

Interior Health

My Name: _____

My Emergency Contact: _____

My Emergency Contact Phone: _____

My Doctor /
Nurse Practitioner: _____

My Advance Care Plan Wallet Card

I have a **MOST** on file: ☐ Yes ☐ No ☐ I don't know

I have signed a **Representation Agreement**: ☐ Rep 9 or ☐ Rep 7

My **Representative/Substitute Decision Maker** is:

Name: _____

Phone Number: _____

I have an **Advance Directive**: ☐ Yes ☐ No ☐ I don't know

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Advance Care Planning Resources

Speak with your Physician or Nurse Practitioner, call your local Interior Health Community Care Office or visit the following websites to learn more about ACP.

Interior Health ACP Resources

Interior Health ACP Website

Interior Health MOST and Goals of Care

Provincial ACP Resources

Indigenous Health ACP Resources

BC Transplant

Government of BC: Wills and Estate Planning Information

National ACP Resources

Advance Care Planning Canada

Living My Culture

Interior Health ACP Contact Info

For more information please email advancecareplanning@interiorhealth.ca

Interior Health wishes to acknowledge and express appreciation to the individuals and partners who contributed to the development of this invaluable workbook!

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