Advanced Care Directive

Name _____

Address _____

Date of Birth _____

If I cannot speak for myself, I would like my doctor to talk about my health care and medical problems to the following person(s): (please write name(s) and contact phone number(s)

1.	
2.	
3.	

I have legally appointed the following:

	Name and contact number of person appointed
Enduring Guardian (Health Decisions)	
Enduring Power of Attorney (Money/finance decisions)	

Who has copies of these legal documents? (Please include contact number of person(s))

If I am very sick or badly injured, and others need to make medical decisions for me, please consider my following statements when making substitute decisions:

The following things are important to me, and I want them to be considered in any decisions that are made on my behalf:

Cardio Pulmonary Resuscitation (CPR) (initial the box that matches your choice)

If my heart or breathing stops due to old age or irreversible (not curable) health problems my choice, if CPR is a treatment option, would be

- ☐ Please try to restart my heart or breathing (**Attempt CPR**)
- ☐ Please allow me to die a natural death. Do not try to restart my heart or breathing (**NO CPR**)
- ☐ I cannot answer this question. Let my doctor decide.

Signature _____ Date _____

Personal Values

Please consider my personal values for the following statements if I am unable to make my own decisions in the future. (Put your initials in the box that is your response to each statement)

I would find life to be ***acceptable*** OR ***difficult but bearable*** OR ***unbearable*** if, for the rest of my life

	ACCEPTABLE	DIFFICULT BUT BEARABLE	UNBEARABLE
I do not recognise my family and loved ones			
I do not have control over my bladder and bowels			
I cannot feed myself, and cannot wash myself, and cannot do my own personal grooming and dressing			
I cannot move myself ar9ound in or out of bed and rely on other people to reposition (shift or move) me			
I can no longer eat or drink and need to have food given to me through a tube in my stomach			
I cannot talk, read and write			

	ACCEPTABLE	DIFFICULT BUT BEARABLE	UNBEARABLE
I can never have a conversation with others because I do not understand what people are saying			
I do not get enjoyment from many of the things that I have always enjoyed			

Talking about end of life:

Please initial the statement which is closest to your personal belief

I am frightened of dying and do not want to think about it happening to me or my loved ones. I do not discuss death or dying with others	
Dying is a fact of life. You just have to deal with it when it happens. I hope that I can talk about it with loved ones and others before my time comes	
Dying is a natural part of life. I am comfortable discussing death and dying with my loved ones and others. I want to be prepared for when my time comes	

When my time for natural dying comes, if possible, I would like to be care for

- ☐ At home or in a home like environment
- ☐ In a hospital or hospital like environment
- ☐ I do not know. I am happy for my family/person responsible to decide

Signature _____ Date _____

Review dates

Witness Date
Signature _____ _____

Additional optional page (not all people will want to include this page. Please staple to advance care plan if you wish this information to be included).

Name _____
Date of Birth _____

Specific requests with regard to medical care (Please initial the box if you wish to identify specific treatment limitations. If you DO NOT have specific requests, please cross out this section)

☐ **I DO NOT WANT** to have the following life prolonging medical treatments

My personal, religious and spiritual care requests

If I am unable to communicate my wishes, please consider that I would want to receive the following care:

SPECIFIC REQUESTS FOR TISSUE, ORGAN AND/OR BODY DONATION (Please initial the small box that is next to the statement you are completing. Please cross out this section if you do not want to make a request).

☐ I have registered as an **ORGAN AND TISSUE** donor with the Australian Organ Donor register. My organ donor registration number is:

_____

I have discussed my organ and tissue donation wishes with my family and friends and they are aware of my decision **YES NO**

I understand that my donation wishes may, in some situations, require the use of life sustaining treatment in an Intensive Care Unit. I understand and accept that I may receive this additional care so my donation wishes can be carried out.

BODY (CADAVER) AND OTHER DONATION

- ☐ I have registered as a cadaver/other donor. Please contact the following number to arrange collection

_____

I understand that there may be specific instructions that need to be followed shortly after my death for cadaver and/or other body part donation to occur. I have discussed what needs to happen with my family/friends YES NO

Your Signature	Date signed
Witness Signature	Date witnessed

My Requests: (Initial ONE box which best describes your wishes)

○ If I am acutely ill, and it is reasonably certain that I will not recover, I want to be allowed to die naturally in my familiar surroundings. I do not want my life prolonged by extraordinary or overly burdensome treatments. I wish to receive palliative care that includes treatments to keep me comfortable, pain relief, and be offered food and drink of my choice.

OR

○ In the event of sudden or significant deterioration in my health I request to be transferred to hospital for assessment and possible treatment. For example: _____

OR

○ I would like all decisions about medical treatments to be made by my doctors and those I have listed below. I request that they consider my wishes as outlined in this Advance Care Plan.

Declaration by competent # person:

I ask that if possible my Enduring Guardian or trusted representative(s) include the following people in discussions and decisions about my health care:

_____ _____
_____ _____
_____ _____
_____ _____

I, _____ (Print name)
declare that the information completed above is a true record of my wishes on this date.

Signature _____

Date _____

Witness Name _____

Witness Signature _____

Relationship _____

Date _____

 # For definition regarding competence please refer to the ACP Information Page

OR

Declaration by Enduring Guardian / Trusted representative (on behalf of a non-competent person):

I, _____ (Print name) declare that the information completed above is a true record on this date.

Signature _____ Date _____ Phone _____

Relationship _____ Address _____

Witness name _____ Witness signature _____

Doctor's review of plan: Date: _____	**Staff Member Completing Form:**
Name: _____	Name: _____
Signature: _____	Signature: _____