Advance Directive for Health Care

This document is directed to any medical practitioner who in the future may be responsible for my medical care, to my legally appointed Enduring Power of Attorney for Personal Care and Welfare, or my Court Appointed Welfare Guardian, and to my family members.

Name:

Address:

NHI:

I have written in this directive my wishes for future health care. I understand that it will only be used when I am unable to make decisions for myself. If any of the following situations arise, it is my wish that the guidelines I ticked below are followed:

- If I have severe or permanent brain damage *or*
- If I have a terminal condition caused by injury or illness for which there is no cure *AND*
- If life sustaining treatment will only prolong the dying process

☐ The primary goal is to relieve any symptoms of pain and/or distress I have and not to prolong my life.

☐ In the event of my heart stopping, regardless of the cause, do not attempt to restart. Allow natural death.

☐ If I become unable to swallow food, fluid, or my regular medications, do not give these by any artificial means.

☐ Other

The object of this directive is to ensure that my wishes are made clear to all medical staff responsible for my care. I would like to avoid anyone, especially my family, having to make difficult decisions on my behalf. Finally I wish to state that by completing this document it is my intention to authorise effective symptom relief for myself in the circumstances described.

I _____ have discussed the circumstances listed in this Advance Directive and the guidelines about care and treatment with Dr_____ [GP or specialist] who has explained the consequences of the Directive to me. I believe I have now had sufficient time to understand and consider that information and sign this document.

I intend this Advance Directive to apply EITHER ***indefinitely /*OR *for the next [ ] years.*** [NB: if specifying the number of years, delete "indefinitely" and complete the number of years you intend the directive to apply for.]

Signed _____ Date: _____

Witness 1

Name: _____

Signature: _____ Date: _____

Witness 2 and witness statement (to be completed by doctor)

I declare that in my opinion the above person is mentally competent, understands the meaning and implications of this directive, and has completed this directive entirely voluntarily.

Name: _____ Designation: _____

Facility / organisation**:** _____

Signature :_____ Date _____