Cabrini

UR No.:

Surname:

Given Name:

D.O.B.:

Please fill in if no patient label available

MY ADVANCE CARE DIRECTIVE

This Advance Care Directive replaces any previous directives that I may have made. I understand that my values and beliefs may be different from those of the people I choose to make decisions for me and I ask them to make the decisions which I would make. I also understand that I can change my Advance Care Directive at any time.

This Advance Care Directive is in effect only when I do not have capacity to make my own decisions.

I have made this Advance Care Directive after discussion with the following health care providers (e.g. doctors, nurses, social workers, etc):

Name: *Role:*

Name: *Role:*

Name: *Role:*

Why?

Have your voice heard

It is good to think about your future health care needs and to discuss these with others.

If a time comes when you are unable to make your own decisions, someone else will be asked to make decisions on your behalf. You can choose who that person is and help that person to represent you by telling them what would be important to you at this stage in your life. This document suggests some of the issues you might like to discuss with both your doctor and the person you have chosen (or who will be chosen) to represent you.

The document is in four parts:

Part 1: choose who you trust to speak on your behalf and who you want to have access to your medical information

Part 2: express the values that are important to you to help your decision-maker

Part 3: give binding instructions about certain medical situations

Part 4: obtain signatures of witnesses to the creation of this document

You may complete all or part of Part 1, 2 and 3.

Part 4 must be completed for this Directive to be valid.

Me

About me

Name:

Date of birth: / /

Address:

Cabrini

MY ADVANCE CARE DIRECTIVE

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Please fill in if no patient label available

Part 1 – Appointment of Medical Treatment Decision Makers and Support Person

Who?

Who will speak for me?

This section allows you to document one or two people who you know well and trust to make health decisions in the event that you are unable to do so for yourself. The second person you list will only be asked if the first person is unavailable.

You can also appoint a Support Person who will help you make decisions while you still have decision-making capacity – they will have access to your medical information. Your Support Person can also be your Medical Treatment Decision Maker.

The people you select to be your Medical Treatment Decision Makers and Support Person must sign this page to accept the role.

Medical Treatment Decision Maker 1	
Name:	
Address:	
DOB:	

Acceptance of appointment: I understand the obligations of an appointed Medical Treatment Decision Maker and undertake to act in accordance with any known preferences and values of the person making the appointment. I undertake to promote the personal and social wellbeing of the person making the appointment and have read and understand any advance care directive that the person has given.

Name: Signature: Date:

Medical Treatment Decision Maker 2	
Name:	
Address:	
DOB:	

Acceptance of appointment: I understand the obligations of an appointed Medical Treatment Decision Maker and undertake to act in accordance with any known preferences and values of the person making the appointment. I undertake to promote the personal and social wellbeing of the person making the appointment and have read and understand any advance care directive that the person has given.

Name: Signature: Date:

Support Person	
Name:	
Address:	
DOB:	

Acceptance of appointment: : I understand the obligations of an appointed Support Person and undertake to act in accordance with any known preferences and values of the person making the appointment. I undertake to promote the personal and social wellbeing of the person making the appointment and have read and understand any advance care directive that the person has given

Name: Signature: Date:

Witnesses to appointment of Medical Treatment Decision Makers and/or Support Person: I certify that the person making the above appointments and the person/people accepting those appointments appear to have decision-making capacity and have freely and voluntarily signed the document

Witness One: Authorised witness

Name:

Signature: Date: / /

Qualification:

Witness Two:

Name:

Signature: Date: / /

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Please fill in if no patient label available

Part 2 – Values Directives

What? **What is important to me?**	We are all unique and have different beliefs, values and goals. Here you can say what is important to you. What does it mean to you to 'live well'? This information will be used by people making decisions for you to help them make the decisions that you would have made yourself. These statements are a guide to treatment decision making only. If you wish to legally refuse treatment, see Part 3 of this form.

1. I am currently receiving care and treatment for the following health conditions:

2. What is difficult for me to do now because of my health conditions?

3. What worries me about what will happen to my health in the future?

4. The following things worry or concern me unrelated to my health. For example: family concerns, hopes and fears, emotional issues, accommodation, people I do not want involved.

5. These are the things in life that have a lot of meaning for me. (For example: enjoying activities, spiritual or religious beliefs, family or friends, pets, reading books, independence.)

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MY ADVANCE CARE DIRECTIVE

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Please fill in if no patient label available

Part 2 – Values Directives continued

6. The following things are important to me and they may help my Medical Treatment Decision Maker to make medical decisions in the future for me (for example: special religious or cultural needs):

7. If I have an illness or injury and can no longer make treatment decisions for myself, I would most likely agree to *(Please tick one box only):*

- ☐ Any treatments that will make me live longer and are suitable for my medical condition (even if they could cause me distress)

Or

- ☐ To be kept comfortable and be provided with treatments that are not distressing and mainly treatments aimed at relief of pain and other symptoms

Or

- ☐ For my Medical Treatment Decision Maker to decide what is best for me, based on what the doctors tell them about me at that time.

8. Other things that are important to me are:

9. If I am nearing death, the following things are important to me (e.g. where I would prefer to die, spiritual/faith rituals or requests, who I would like with me, funeral preferences)

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Part 3 – Instructional Directives

What?

What treatment decisions have you already made?

If you wish your Medical Treatment Decision Maker and healthcare providers to be able to take into account your circumstances when you are not able to make decisions, you should use **Part 1** and **Part 2** of this form only. **Part 4** must also be completed

In **Part 3** you can make binding statements called 'Instructional Directives' that will communicate your medical treatment decision directly to your healthcare providers.

It means that no-one else will be asked to make decisions about those treatments for you. It is very important that you consult your health practitioner if you choose to

complete an Instructional Directive, in order to ensure that it is written in a way that can be safely interpreted. If your Instructional Directives are unclear, they will still be considered as descriptions of your values.

To give more general guidance to your Medical Treatment Decision Maker see Part 2 of this form. **Cross out this page if you do not wish to consent to or refuse any specific medical treatments.**

10. **Cardiopulmonary Resuscitation (CPR) involves chest compressions and artificial ventilation to manually save brain function, blood circulation and breathing for someone in cardiac arrest. These interventions are used when a person's heart stops beating, and they may or may not restore life.**

If my heart stops beating:

☐ Attempt resuscitation if clinically indicated

Or

☐ Do NOT attempt resuscitation

Comment:

11. **Organ donation:** Very few people die in a way that allows them to be considered for organ donation. One organ donor can save or improve the lives of many others. Your family will be asked to confirm your consent for donation.
In the event that I am able to be considered for organ, eye and/or tissue donation when I die, I wish to be a donor:

☐ Yes ☐ No

12. Here you can write other **Instructional Directives**. Keep in mind that these should include details about the circumstances in which the directive will apply, as well as specifics of the treatments to which you either give or refuse consent e.g. "If I am ever suffering from (*insert details of condition*), I give my consent to/refuse (*insert details of treatment*).

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Part 4 – Witnessing and signatures

Your Declaration:

I make this Advance Care Directive and any appointments within it freely and voluntarily, and I understand the nature and effect of each statement within the Directive.

Name:

Signature: Date: / /

Witnesses to the signing of this Advance Care Directive: I certify that the person giving this Advance Care Directive appears to have decision-making capacity and has freely and voluntarily signed the document in the presence of two witnesses, neither of whom has been appointed as a Medical Treatment Decision Maker. The person appears to understand the nature and effect of all statements made within this document.

Witness One: Registered Medical Provider

Name:

Signature: Date: / /

Qualifications:

Witness Two:

Name:

Signature: Date: / /

Sharing your Advance Care Directive

I understand that it is important to discuss these healthcare preferences with my GP, Medical Specialists, local hospital, my family / friends and particularly my Medical Treatment Decision Makers. I have discussed and provided a copy of My Advance Care Directive to the following people:

Name	Contact Phone Number