This document is to record your wishes about treatment that you would like to have in the event of a life-threatening illness or injury and any treatments that you would refuse. It would only be referred to in circumstances where you cannot make these decisions yourself. Your doctor will consider this Advance Care Directive valid and legally enforceable if:

- you had capacity when you wrote it and you made it voluntarily
- It has clear and specific details about treatments that you would accept or refuse
- It is current and extends to the circumstances at hand.

Illness, disease and other life events are unpredictable, and it is best to provide general guidance about your future medical treatment, rather than specific directives. A trusted representative who knows you well can discuss with the doctors and nurses the options for care that are appropriate at the time. Specific directives ahead of time may not meet your needs in the actual circumstance, therefore your decisions should allow flexibility to guide appropriate care. Healthcare professionals may assist in guiding these decisions according to your medical situation at the time. Support and care will be provided to control pain and other symptoms, and ensure you are as comfortable as possible.

DEFINITIONS

Cardio Pulmonary Resuscitation (CPR): CPR can be used if your heart stops beating. It could involve resuscitation breaths and heart massage. It could also involve drugs being injected into your veins, electric shocks to your heart and a breathing tube being put in your throat.

Capacity: means that you understand the facts and choices involved, weigh up the consequences and can determine your decision.

No Cardio Pulmonary Resuscitation (CPR): If your heart stops beating no attempt will be made to resuscitate you, allowing a natural death.

Enduring Guardian: This is the person appointed by you to legally make medical and dental decisions on your behalf if you do not have capacity.

Person Responsible: This is the person who is legally able to make medical and dental decisions on your behalf if you do not have capacity. The person responsible is predetermined by a hierarchy (see SECTION 1) as stated in NSW legislation. Alternatively you can appoint the person of your choice as your Enduring Guardian.

Feeding (food and fluids):

- Intravenous (‘drip’) - If necessary and appropriate, you would be given fluids and/or nutritional supplements through a vein.
- Tube - If necessary and appropriate, you would be fed through a tube that goes through the nose into the stomach (nasogastric tube) or it could be a tube which goes through the skin into the stomach (a gastrostomy tube).

Level of functioning: refers to how your illness affects your physical and mental abilities. Decisions around your level of functioning need to be made carefully with regard to the quality of recovery and trials of suitable therapy.
SECTION 1: MY ‘PERSON(S) RESPONSIBLE’

This section is to help your treating clinicians to identify the ‘Person(s) Responsible’ for your healthcare decisions, by using the framework provided by law in the NSW Guardianship Act. This person is your legal substitute who, in the event that you are not able to make decisions, can make decisions about your medical treatment on your behalf which are based on the wishes and decisions you express in this Directive. Your Person Responsible should be someone you trust and with whom you have discussed your choices. You are encouraged to legally appoint this person as your Enduring Guardian for medical and lifestyle decisions and care. For more information discuss with your legal representative or visit: www.planningaheadtools.com.au

1 I have appointed someone as my Enduring Guardian to consent to my medical treatment. (Tick ‘Yes’ or ‘No’ below)

<table>
<thead>
<tr>
<th>Yes</th>
<th>If Yes, go to Section 2 and provide their details</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>If No continue to 2 below</td>
</tr>
</tbody>
</table>

2 I have a spouse or defacto with whom I have a close, continuing relationship. (Tick ‘Yes’ or ‘No’ below)

<table>
<thead>
<tr>
<th>Yes</th>
<th>If Yes, go to Section 2 and provide their details</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>If No continue to 3 below</td>
</tr>
</tbody>
</table>

3 I have an unpaid carer who provides or previously provided me with support. (Tick ‘Yes’ or ‘No’ below)

<table>
<thead>
<tr>
<th>Yes</th>
<th>If Yes, go to Section 2 and provide their details</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>If No continue to 4 below</td>
</tr>
</tbody>
</table>

4 I have a close friend or relative. (Tick ‘Yes’ or ‘No’ below)

<table>
<thead>
<tr>
<th>Yes</th>
<th>If Yes, go to Section 2 and provide their details</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>If No, consider appointing an Enduring Guardian</td>
</tr>
</tbody>
</table>

SECTION 2: DETAILS OF PERSONS ABOVE

These are the details of my Enduring Guardian/s or other persons who may make decisions about my care if I am unable to do so. If an Enduring Guardian is appointed, keep a copy of the “Form of Appointment of Enduring Guardian/s” with this Directive and submit to hospital with this Directive as outlined in section 7.

Name: ____________________________________________________________

Address: __________________________________________________________

Phone Home: ______________________ Work: ______________________ Mobile: ______________________

Email: ____________________________________________________________

If you have more than one person responsible please provide details and instructions around their responsibilities and the need for consensus:

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

_________________________________________________________________

ENSURE YOU KEEP THIS ORIGINAL – COPIES TO GP AND HOSPITAL

Initial: ______
SECTION 3: MEDICAL CARE

This section is meant as a guide to assist you to record your preferences about your healthcare. If you are not comfortable making these decisions or are uncertain, discuss with your doctor and your Person Responsible or Enduring Guardian situations or circumstances you consider that you would or would not want for yourself. These may include situations or circumstances you have experienced or witnessed.

The levels of functioning affecting my quality of life I would find unacceptable include:

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Specific directives ahead of time may not meet your needs in the actual circumstances, therefore your decisions should allow flexibility to guide appropriate care. Your treating doctor is not obliged to provide non beneficial treatments. Healthcare professionals may assist in guiding these decisions according to your medical situation at the time.

If ill or injured and not expected to get better, so that my level of functioning would not be acceptable to me:

In cardiac arrest, I request: ‘Cardio Pulmonary Resuscitation’ or ‘No Cardio Pulmonary Resuscitation’

Write exact wording from options in boxes below

If I need fluid or food and cannot safely swallow, I request: ‘tube’ or ‘intravenous’ or ‘to eat and drink as I may want’ or ‘uncertain’

If required, blood transfusion or blood products should be considered: Yes or No

When I am near the end of my life, if circumstances allow, I wish to die: ‘At home’ or ‘in a palliative care unit’ or ‘my Person Responsible can decide’ or ‘uncertain’ or ‘other location’

Even if expected to get better, are there any treatments that you would never want?

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

If I am ill and unable to make my own decisions the following would be important to me (e.g. these things may include cultural, spiritual and social needs.)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Has organ or tissue donation been considered or discussed? □ Yes □ No

Have you registered your decision with the Australian Organ Donor Register? □ Yes □ No

If you would like more information please discuss with your doctor or visit www.donatelife.gov.au/

It is important to discuss your decision to donate organs with your person responsible.

ENSURE YOU KEEP THIS ORIGINAL – COPIES TO GP AND HOSPITAL

Initial: ______
SECTION 4: PERSONAL DETAILS AND SIGNATURE

This Advance Care Directive sets out what kind of healthcare treatment I want if I am unable to make my own decisions in the future. It should be followed if I am not able to give my consent to treatment because of illness, injury or dementia affecting my capacity. I expect to be included in discussions regarding my care if I am able to communicate. This directive is applicable if I am at home or hospitalised.

I, _______________________________________________ (print name)
Address: __________________________________________________________
am voluntarily completing this Advance Care Directive of my own free will on this date: ____/____/_____
Signature: _______________________________________________________________________________

Please initial in space provided at bottom of pages 2 and 3 after signing the directive.

If used, Professional Interpreter name: ________________ Signature:_____________  Organisation:_____

SECTION 5: WITNESS SIGNATURE

It is strongly recommended that the above signature is witnessed.

I am the witness to this directive. I ___________________________ (Print name) verify that ___________________________________________ (print name of person completing Directive) signed this directive on this date: ____/____/_____ of his/her own free will, without threats or offered inducements. I am not a relative of the person completing this directive, nor of the person(s) responsible and I am not involved in the person's medical treatment.

Name: ________________________________________ Signature __________________________________
Address: ____________________________________________________ Phone: ______________________

SECTION 6: TREATING HEALTH CARE PROFESSIONAL

Name: ___________________________________________________________________________________
Address: _________________________________________________________________________________
Phone (work): ____________________________________ (fax): ____________________________________
Email: ___________________________________________________________________________________

At the time of discussions ________________________(print name) was competent and informed with respect to the decisions documented within this Directive.

Signature: ____________________________________________________________ Date: ____/____/_____