NSW GOVERNMENT Health

SECTION 1 YOUR DETAILS AND YOUR PERSON RESPONSIBLE

Family name: ____________________

Given names: ____________________

Date of birth: ____________________

Address: ____________________

____

I have legally appointed one or more people as my Enduring Guardian and they are aware of this Advance Care Directive:

	ENDURING GUARDIAN 1	ENDURING GUARDIAN 2
Name:		
Home phone number:		
Mobile phone number:		
Email address:		

I have not appointed an Enduring Guardian.

If, because of my medical condition, I am not able to understand and make decisions about my treatment or can't tell the doctors or my family, my Person Responsible is:

	PERSON 1	PERSON 2
Name:		
Relationship:		
Home phone number:		
Mobile phone number:		

SECTION 2 PERSONAL VALUES ABOUT DYING

Information about your values is important as it is not possible for this document to cover all medical situations. Information about what is important to you may help the person who is making decisions on your behalf when they are speaking to the doctors about your care and treatment.

In this section you can include:

- things that are important to you at the end of life (your beliefs and values)
- issues that worry you, and
- personal, religious or spiritual care you would like to receive when you are dying.

If I am unable to communicate and not expected to get better:

- I would like my pain and comfort managed; and
- when deciding what treatments to give to me or not to give me, I would like the person/people making health decisions for me to understand how the following would make me feel (initial the box that is your choice):

VALUES	Acceptable	Unbearable (I would like treatment discontinued and to be allowed to die a natural death)	Unsure
1. If I can no longer recognise my family and loved ones, I would find life...	☐	☐	☐
2. If I no longer have control my bladder and bowels, I would find life...	☐	☐	☐
3. If I cannot feed, wash or dress myself I would find life...	☐	☐	☐
4. If I cannot move myself around in or out of bed and rely on other people to reposition (shift or move) me, I would find life...	☐	☐	☐
5. If I can no longer eat or drink and need to have food given to me through a tube in my stomach, but can still communicate, I would find life...	☐	☐	☐
6. If I am not able to communicate by talking, reading or writing, I would find life...	☐	☐	☐
7. If I can never have a conversation with others because I do not understand what people are saying, I would find life...	☐	☐	☐

SECTION 2 PERSONAL VALUES ABOUT DYING

At the end of my life when my time comes for natural dying, I would like to be cared for (initial the box of your choice)

At home or in a home like environment ☐

In a hospital or hospital like environment ☐

Other location (please provide details) ______________________ ☐

I do not know. I am happy for my family / Person Responsible to decide. ☐

When my Person Responsible is making decisions about care at the end of my life, I would like them to consider the statements below.

If you need extra space please attach an additional page.

I do not want to complete Section 2:

____

(Signature)

SECTION 3 DIRECTIONS ABOUT MEDICAL CARE

This section applies to when you are unable to make or communicate decisions about your health care and medical treatment, including CPR.
If you are able to communicate you will be included in decisions about your care.

Cardio Pulmonary Resuscitation (CPR)

CPR refers to medical procedures that may be used to try to start your heart and breathing if your heart or breathing stops. It may involve mouth to mouth resuscitation, very strong pumping on your chest, electric shocks to your heart, medications being injected into your veins and/or a breathing tube being put into your throat.

If I am ill or injured and not expected to get better, or if my quality of life is unbearable as indicated in the table on page 3, if my heart stops and CPR is an option (please initial one box only):

Please try to restart my heart or breathing (**Attempt CPR**) ☐

OR

Please allow me to die a natural death. Do not try to restart my heart or breathing (**No CPR**) ☐

OTHER MEDICAL TREATMENTS

If I am ill or injured and **not expected to get better**, or if my quality of life is unbearable as indicated in the table on page 3, **I DO NOT WANT TO HAVE** the following medical treatments (initial the box/boxes that are your choice):

Artificial ventilation (also called life support, breathing machine) ☐

Artificial feeding ☐

Renal dialysis ☐

OTHER: Please list below

Even if I am expected to get better I would never want the following medical treatments:

I do not want to complete Section 3:

____

(Signature)

SECTION 4 SPECIFIC REQUESTS FOR ORGAN AND TISSUE DONATION

My wishes about organ and tissue donation for transplantation following my death are (initial your choice for each statement):

	Yes	No
I would like to donate my organs and tissues for transplantation following my death.		
I have discussed my organ and tissue donation wishes with my family and friends and they are aware of my decision.		
I have registered my wishes on the Australian Organ Donor Register.		

Antemortem treatment for organ donation (treatment/s immediately before my death only for the purpose of organ donation)

	Yes	No
It is my wish to donate my organs for transplantation after my death. If I am dying, I consent to the doctors providing treatments before my death (including artificial ventilation, insertion of intravenous lines and administration of medications) intended only for the purpose of enabling me to donate my organs and tissue for transplantation.		

I do not want to complete Section 4:

____

(Signature)

SECTION 5 AUTHORISATION

PERSONAL DETAILS

By signing this document, I confirm that:

- I have read the accompanying information booklet, or had the details explained to me
- I understand the facts and choices involved, and the consequences of my decisions
- I am aware that this Advance Care Directive will be used in the event that I cannot make or communicate my own health care decisions. If I am able to communicate, I will be included in decisions about my care.
- I have completed this Advance Care Directive of my own free will.

_______________________________ (Signature) ____/____/____ (Date)

DETAILS OF WITNESS*

I can confirm that _______________________________ signed this document on ____/____/____

Signed: _______________________ Name (please print): _______________________

Address: _______________________ Phone: _______________________

TREATING HEALTH PROFESSIONAL*

Name: _______________________ Phone: _______________________

Address: ____

Email: ____

I confirm that _______________________________ had capacity and was aware of the implications of the information in this Advance Care Directive.

_______________________________ (Signature) ____/____/____ (Date)

*While not legally required, it is strongly recommended that a health professional co-signs this Advance Care Directive and/or a person witnesses you sign this form.

NSW MINISTRY OF HEALTH
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source.
It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above requires written permission from the NSW Ministry of Health.

© NSW Ministry of Health 2017

SHPN (OCHO) 170184
ISBN 978-1-76000-632-7

Further copies of this document can be downloaded from the NSW Health website www.health.nsw.gov.au

May 2017