

Advance care directive for adults

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

Any advance care directive that you have previously made under this Act is automatically revoked (cancelled) when you complete this advance care directive.

This form is designed for adults to complete using the *Instructions for completing the advance care directive form* document.

Part 1: Personal details

You must fill in your full name, date of	Your full name:		
birth and address. A phone number is optional.	Date of birth: (dd/mm/yyyy)		
	Address:		
	Phone number:		
If you have no current health problems, cross out this section.		nealth problems are:	
It is helpful to know if you have completed an Advance Statement in relation to a mental illness.	I have completed an Advance Statement under the Ation Mental Health Act 2014 (Vic.).		





nce care direct	ive of:
t your full nam	e)

Part 2: Values directive

In Part 2 you can write your values and preferences for your medical treatment. Refer to Part 2 a) of the instructions.

Refer to Part 2 b) of the instructions.

Your medical treatment decision maker is legally required to first consider your values directive when making decisions about your medical treatment.

Identify who your medical treatment decision maker is and discuss your preferences and values with them. You can appoint someone using the *Appointment of a medical treatment decision maker* form. Refer to Part 2 of the instructions for more information.

You may complete all, some, or none of the sections.

a) What matters most in my life: (What does living well mean to you?)

b)	What worries	me most	about my future:	

c) For me, unacceptable outcomes of medical treatment after illness or injury are: (For example, loss of independence, high-level care or not being able to recognise people or communicate)

Part 2 c) of the instructions includes a table with examples of health outcomes to help you complete this section.



For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	
(insert your full name)	Advance care directive of:
(insert your full name)	
	(insert your full name)

Part 2: Values directive (cont.)

Refer to Part 2 d) of the

Things you can include about your values and preferences are:

spiritual, religious,

treatment for mental

or cultural requirements your preferred place

of care treatment with prescription pharmaceuticals (medicine)

illness

procedures.

Refer to Part 2 e) of the instructions.

instructions.

d) Other things I would like known are:

medical research			
procedures			

e) Other people I would like involved in discussions about my care:

f)	If I am nearing death the following things would be important
	to me:

Refer to Part 2 f) of the instructions. Things to consider include: persons present, spiritual care, customs or cultural beliefs met, music or photos that are important.

Select **one** statement below and mark your response with an X.

I am willing to be considered for organ and tissue donation, and recognise that medical interventions may be necessary for donation to take place.

I am not willing to be considered for organ and tissue donation.



	Advance care directive of:	
((insert your full name)	

Part 3: Instructional directive

This instructional directive is legally binding and communicates your medical treatment decision(s) directly to your health practitioner(s). It is recommended that you consult a medical practitioner if you choose to complete this instructional directive.

- Your instructional directive will only be used if you do not have decision-making capacity to make a medical treatment decision.
- Your medical treatment decisions in this instructional directive take effect as if you had consented to, or refused to, begin or continue medical treatment.
- If any of your statements are unclear or uncertain in particular circumstances, it will become a values directive.
- In some limited circumstances set out in the Act, a health practitioner may not be required to comply with your instructional directive.

Cross out this page if you do not want to consent to or refuse future medical treatment.

 Refer to Part 3 of the instructions for more information on how to complete your instructional directive. Keep in mind: you should include details about the circumstances in which you consent to or refuse treatment health practitioners can only offer treatment that 	 a) I <u>consent to</u> the following medical treatment: (Specify the medical treatment and the circumstances) b) I <u>refuse</u> the following medical treatment: (Specify the medical treatment and the circumstances)
 is medically appropriate in an end-of-life care situation, certain medical interventions may be required for organ and tissue donation to take place. 	



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Part 4: Expiry date (optional)

Only complete this part if you want this advance care	This advance care directive expires on: (dd/mm/yyyy)	
directive to have an		
expiry date. Refer		
to Part 4 of the		

Part 5: Witnessing

You must sign in front of two adult witnesses.

instructions.

One witness must be a registered medical practitioner.

Neither witness can be a person that you have appointed as your medical treatment decision maker.

Refer to Part 5 of the instructions if someone else is signing on your behalf.

A registered medical practitioner must complete this part of the form.

Signature of person giving this directive (you sign here)

Each witness certifies that:

- at the time of signing the document, the person giving this advance care directive appeared to have decision-making capacity in relation to each statement in the directive and appeared to understand the nature and effect of each statement in the directive; and
- the person appeared to freely and voluntarily sign the document; and
- the person signed the document in my presence and in the presence of the second witness; and
- I am not an appointed medical treatment decision maker of the person.

Witness 1 – Registered medical practitioner

Full name of registered medical practitioner:

Qualification and AHPRA number of registered medical practitioner:

Signature of registered medical practitioner: Date: (dd/mm/yyyy)

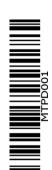
Witness 2 – Adult witness

Full name of adult witness:

Signature of adult witness:

Date: (dd/mm/yyyy)

Another adult witness must complete this part of the form.



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If an interpreter is present when this document is witnessed

If an interpreter is	Name of interpreter	ſ:		
present at the time the document is				
witnessed, they	If accredited with the National Accreditation Authority			
complete this section immediately	NAATI number:			
after the document is witnessed.	I am competent to interpret from English into the following language:			
	I provided a true ar of the document.	nd correct interpretation t	o facilitate the witnessing	
	Signature of interpr	reter:	Date: (dd/mm/yyyy)	

Part 6: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter helped you to prepare this document, they complete this section. They can fill in this section before the document is witnessed or at the time the document is witnessed. Refer to Part 6 of the instructions.	Name of interprete	r:	
	If accredited with the National Accreditation Authority		
	NAATI number:		
	I am competent to	interpret from English into the	following language:
	When I interpreted into this language the person appeared to understand the language used in the document.		
	Signature of interp	reter:	Date: (dd/mm/yyyy)

You have reached the end of this form.

It is recommended that you **review your advance care directive every two years**, or whenever there is a change in your personal or medical situation.

- Please keep your original advance care directive safe and accessible for when it is needed.
- Ensure that your medical treatment decision maker (if any) has read and understood its contents.
- Your advance care directive can be uploaded on MyHealth Record and should be shared with your medical treatment decision maker and relevant health practitioner(s) / health service(s).