dying with dignity victoria

respect for the right to choose

DWDV Form 3a

Advance Care Directive

Made under the

Medical Treatment Planning and Decisions Act 2016 (Vic.)

Once filled in, signed and witnessed, this Advance Care Directive replaces any previous Advance Care Directive you may have made. Dying With Dignity Victoria strongly recommends you complete this form only after careful consideration.

1. Personal Details

Name:	
Address:	
State:	
Postcode:	
Date of birth:	

My current health status at the time of signing:

◯	I am in good health
◯	My GP/Specialist has diagnosed me with *(describe your diagnosis)*:

Signed: _____

2. Instructional Directive

This Instructional Directive is **legally binding** and communicates your medical treatment decisions directly to your health practitioners. Dying With Dignity Victoria strongly recommends you consult a medical practitioner if choosing to complete this Instructional Directive.

- **Your Instructional Directive will only be used if you do not have 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 (see page 5).
- In some limited circumstances set out in the Act, a health practitioner may not be required to comply with your Instructional Directive.

Applying this Instructional Directive

This Instructional Directive must apply **unless**:

	Agree	Disagree
I am suffering only a transient (temporary) loss of competence, such as hypoglycaemia or TIA (transient ischaemic attack) or mild concussion.	○	○
I am suffering from a severe illness but in the opinion of two independent medical practitioners (at least one a specialist), I am likely to recover to a state of independence and competence, without profound physical or psychological suffering.	○	○

Subject to the above conditions in “Applying this Instructional Directive”,
I declare that in respect of medical intervention or treatment aimed at prolonging or sustaining my life:

Treatment	I refuse	I accept
Artificial feeding (nutrition and / or hydration)	◯	◯
Antibiotics	◯	◯
Artificial respiration	◯	◯
Any surgical procedures	◯	◯
Circulatory support, including CPR	◯	◯
Corrections of abnormal levels of any toxic substance	◯	◯
Blood transfusion	◯	◯
Drug treatment of high / low blood sugar	◯	◯
Drug treatment of high / low blood pressure	◯	◯
Renal dialysis	◯	◯

Further, I declare that any persistent distressing symptoms (pain, breathlessness, and those caused by lack of food and fluid) are to be **maximally palliated** by appropriate analgesic, sedative or other palliative treatment (including keeping lips, mouth and eyes moist), even though that palliative treatment may also have the additional consequence of shortening my life.

Signed: _____

Dementia

If I have been diagnosed with dementia and am judged by a doctor as not competent to make decisions regarding my medical treatment, and

- ◯ Regardless of whether my primary care is in the home / community, or in an institution
- ◯ Only if I have been admitted to ongoing institutional care

then **I declare** that I refuse any medical treatment with the purpose or outcome of prolonging my life**:**

- ◯ Even if I appear to be content as judged by my Medical Treatment Decision Maker.
- ◯ Except if I appear to be content as judged by my Medical Treatment Decision Maker.

I also declare that:

- ◯ I refuse nutrition / hydration by assisted spoon feeding in any circumstances
- ◯ I accept spoon feeding but only if I appear to accept spoon feeding voluntarily and enjoy my food, as judged by my Medical Treatment Decision Maker.

3. Values Directive

Refer to the MyValues website (www.myvalues.org.au) for ideas to help guide responses to this section.

If you have properly completed and signed the Instructional Directive on pages 2-3, it takes precedence over preferences you may express in this Values Directive. **Make sure there is nothing in your Values Directive that contradicts what you have instructed in your Instructional Directive.**

You do not have to complete all sections of this Values Directive.

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

Points to consider in this section could be religious or cultural beliefs, family and friends, spiritual interests, and independence. Explain why these are important to you, so that your Medical Treatment Decision Maker understands what quality of life means to you.

(b) What worries me most about my future is:

For some people, this could include being in pain, moving into a care facility, not being able to maintain personal care, being unable to participate in social/family activities, or losing the ability to communicate.

(c) For me, unacceptable outcomes of medical treatment after illness or injury are:

For some, being unable to recognise family and friends would be unacceptable. Others may not wish to be reliant on machinery or carers.

(d) Other things I would like known are:

Other matters you wish your Medical Treatment Decision Maker to take into consideration. These could be your preferred place of care, medical treatment procedures, or spiritual/religious/cultural requirements.

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

Provide your Medical Treatment Decision Maker with details of any other person you would (or would not) like involved in discussions about your medical care.

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

Consider the people you would like present. You may wish for your favourite music to be played, or photos to surround you or to have your pet with you.

Organ Donation

In the event of my death:

◯	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.

I declare that I have completed this document after careful consideration.

I reserve the right to revoke this Advance Care Directive at any time, but unless I do so it should be taken to represent my continuing directions.

Signed: _____

4. Medical Treatment Decision Makers

PLEASE NOTE: This section only lists your Medical Treatment Decision Maker/s. It does not officially appoint a person to the role of Medical Treatment Decision Maker. This must be done by completing the form *Appointment of a Medical Treatment Decision Maker.*

I have appointed as my Medical Treatment Decision Maker/s:

Medical Treatment Decision Maker 1

Name:	
Date of birth:	
Address:	
Phone number:	

Medical Treatment Decision Maker 2

Name:	
Date of birth:	
Address:	
Phone number:	

5. Witnessing

You must sign in front of two adult witnesses.

Witness 1 must be a medical practitioner. Witness 2 can be another adult.

Neither witness can be a person you have appointed as your Medical Treatment Decision Maker.

Your signature:	
Date:	

Each witness certifies that:

- At the time of signing the document, the person giving the Advance Care Directive appeared to have decision-making capacity in relation to each statement in the Directive
- At the time of signing the document, the person giving the Advance Care Directive appeared to understand the nature and effect of each statement in the Directive
- The person appeared to freely and voluntarily sign the document
- 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:	
Qualification and AHPRA number:	
Signed:	
Date:	

Witness 2 - Another adult

Full name:	
Signed:	
Date:	

What to do with this form

- Keep the original form with you. Give copies to your Medical Treatment Decision Maker, family, friends and any treating doctors. Keep spare copies with you in case you are admitted to hospital or will be treated by any additional doctors or health practitioners.
- Ensure your Medical Treatment Decision Maker has read and completely understands the form.
- Your Advance Care Directive may be uploaded onto the My Health Record.

Reviews

Dying With Dignity Victoria strongly recommend you regularly review this document, as your wishes may change or there may be advances in medical technology. You would be wise to review the document every two years or if the state of your health changes significantly.

Each time you review your document and your wishes have not changed, sign and date one of the acknowledgements below. If your wishes have changed, you must complete a new Advance Care Directive.

Review of Document: 1

I affirm that I have reviewed this document and there is nothing I would like to change.

Signed:	
Date:	

Review of Document: 2

I affirm that I have reviewed this document and there is nothing I would like to change.

Signed:	
Date:	

Review of Document: 3

I affirm that I have reviewed this document and there is nothing I would like to change.

Signed:	
Date:	