UR NUMBER...

SURNAME...

GIVEN NAMES...

DATE OF BIRTH ....
Please fill in if no Patient Label available

I .... (write name) understand that this document will only be used to inform future medical and health care decisions if I lose the capacity to make decisions for myself. I ask my agent, family and the health care team to use my values and preferences to guide their decision making. I ask you to follow my wishes in this Advance Care Directive as closely as possible and to make the decisions you believe I would make, based on the information I have provided here.

1. Preferred Substitute Decision-Maker For Medical Treatment

Medical Enduring Power of Attorney: Have you legally appointed a Medical Enduring Power of Attorney (Agent) to consent or refuse treatment on your behalf if you lose the capacity to do so?

☐ No

☐ Yes

Name of Agent: .... Telephone: ....

Name of Alternate Agent: .... Telephone: ....

2. Values and Beliefs

What do you most value in life? For example: What interests or activities do you enjoy? What mental or physical functions are most important for you to have a reasonable quality of life? What personal, cultural, spiritual or religious values are important to you?

3. State of Health

What are your health problems or medical conditions? How do these affect your life?

V1 15/05/2014 Developed by 'The Peninsula Model' Advance Care Planning Working Group in collaboration with the Advance Care Planning Service, Peninsula Health, Victoria www.peninsulahealth.org.au/services/services-a-e/advance-care-planning/

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4. Goals for Care

Taking into consideration your personal values, beliefs and health, how much medical intervention would you **prefer and accept if your health seriously deteriorates** and you are unable to agree or object to treatment?

Sign your initials in the box that best describes your preferred level of treatment.

Comfort Care - Palliative Treatment

Promote comfort, dignity and quality of life

- Order tests only for the purpose of managing symptoms effectively
- Provide treatments to achieve good pain relief and to ease any distressing symptoms
- Do surgical procedures only if considered the most effective measure to relieve pain or improve comfort
- Provide therapies that contribute to physical, spiritual, mental and emotional comfort

Restorative Care - Limited Treatment

Restore wellness and physical function by treating all reversible conditions

- Provide essential tests, treatments and therapies to aid recovery from illness and reverse declining function where this is possible. Admit to hospital if necessary for investigations or treatment.
- Provide surgery to treat painful or reversible conditions where risks do not outweigh potential benefits
- Avoid burdensome treatments, intensive care and life support machines

Curative Care - Active Treatment

Aggressively treat all life threatening conditions to gain a possible cure

- Provide all standard medical and surgical treatments to cure the condition where this is possible
- Admit to intensive care for close monitoring, a short trial of treatment, or to aid recovery from surgery using mechanical ventilation (breathing machine)
- Avoid high risk surgery with a significant risk of death or very serious complications

Life Prolonging Care - Intensive Treatment

Do everything medically possible to prolong life

- Use all available life support including mechanical ventilation (breathing machine); drug infusions to maintain blood pressure; procedures or devices to maintain heart rhythm and function; renal dialysis (kidney machine); tubes to drain lungs, stomach, bowel or bladder.
- Remain in a hospital intensive care unit for extended periods (weeks to months)
- Do high risk surgery, even if there is a significant risk of death or very serious complications

Other considerations or points to include or exclude in my care:

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UR NUMBER...

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5. Limitation of Treatment

Are there any situations where you would prefer treatment to keep you comfortable rather than prolong your life or delay your death from natural causes?

☐ No

☐ Yes - describe below

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6. Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary Resuscitation may not be available or considered medically suitable depending on your pre-existing level of health and medical condition. If first attempts to revive you are successful, further life support treatments and hospitalisation will be necessary.

Sign your initials in the box to indicate your **preference** for receiving Cardiopulmonary Resuscitation

☐ If my heart stops beating or there are no signs of life **I would like** Cardiopulmonary Resuscitation to be commenced in an attempt to restart my heart.

☐ If my heart stops beating or there are no signs of life **I do NOT** want Cardiopulmonary Resuscitation commenced in an attempt to restart my heart

Special considerations that apply to your preference for cardiopulmonary resuscitation:

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7. Tube Feeding

If you are permanently unable to safely swallow enough food and fluids to sustain your life would you accept liquid food given through a tube surgically inserted directly into your stomach (PEG tube)?

☐ No

☐ Yes

Special considerations that apply to your preference for tube feeding:

....

....

....

8. Refusal of Specific Treatment

Are there any **specific medical or surgical treatments** that you would **NOT** consent to in the future, even if these might save or prolong your life?

☐ No

☐ Yes (consider completing a legally binding Refusal of Treatment Certificate with your doctor)

Specific treatments that I would refuse under all circumstances are:

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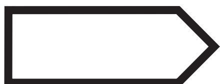
9. Preferred Location of Care

If you are nearing the end of your life and your **health seriously deteriorates** where would you prefer to be cared for? **Sign your initials** in the box that **best describes** your **preference**

If circumstances allow and time permits I prefer:

To transfer to a hospital

To be cared for at home or in my usual residential care facility. Avoid transfer to hospital unless it is not possible for my usual carers, doctor and community based support services such as home hospice nurses to provide the necessary care.



To be cared for in a hospice or palliative care unit

Special considerations that apply to preferred location of care:

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UR NUMBER..

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10. End of Life Care

If you are dying what kinds of things would bring you comfort or be important to you?

Examples: physical touch; favourite music; favourite food or drink; family presence; special items of significance; cultural rituals or customs; religious, spiritual or pastoral care, clergy visits, prayer.

If death is near I would like the following:

11. Organ Donation

What are your views on organ and tissue donation?

Would you like to donate your body organs and tissues if circumstances allow? Yes ☐ No ☐

Have you registered to donate your body to science after death? Yes ☐ No ☐

Comments:

12. Additional information

Is there any further information that you would like known about your future health care preferences or other messages you would like to write here for your agent, family and the healthcare team?

UR NUMBER...

SURNAME...

GIVEN NAMES..

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Competent Person's Declaration

I declare that the information completed in this Advance Care Directive is a true record of my own choices and preferences. I do so of my own free will and have not been unduly influenced or coerced by any person to complete or sign this document. I have carefully considered my choices and understand that they will influence the nature of the medical care provided to me in the future when I am unable to participate in decision-making.

Signature: .... Date: ..../.............../.............

Print Name: ....

Print Address:
....
....
....

Doctor's Declaration

I consider that (*name of person*) .... currently has the capacity to make personal choices and decisions regarding their future medical treatment and is doing so voluntarily. The contents should be taken into account when considering medical treatment for this person if a loss of capacity is suffered in the future.

Signature: .... Date: ..../.............../.............

Print Name: ....

Medical Practice or Hospital Address:
....
....
....

To ensure your Advance Care Directive continues to accurately reflect your wishes, it is recommended that you **review it** regularly, especially if there is an important change in your personal or medical circumstances. It will be necessary to rewrite the form if there are significant changes in your preferences.

Date of Review	Your Signature (Competent Person)