COHUNA DISTRICT HOSPITAL

Po Box 317, Cohuna 3568
Phone: 54 565 300
Fax: 54 562 627

AFFIX PATIENT LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____

SEX: _____

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 birth and address. A phone number is optional.

Your full name:	
Date of birth: (dd/mm/yyyy)	
Address:	
Phone number:	

If you have no current health problems, cross out this section.

My **current** major health problems are:

It is helpful to know if you have completed an Advance Statement in relation to a mental illness.

Mark with an X if the statement below is relevant to you.

I **have** completed an Advance Statement under the *Mental Health Act 2014* (Vic.).	☐

Po Box 317, Cohuna 3568
Phone: 54 565 300
Fax: 54 562 627

AFFIX PATIENT LABEL HERE
U.R. NUMBER: _____
SURNAME: _____
GIVEN NAME: _____
DATE OF BIRTH: _____/_____/_____
SEX: _____

ADVANCE CARE DIRECTIVE FOR ADULTS
made under the Medical Treatment Planning and Decisions Act 2016 (Vic.)

Advance care directive of: (insert your full name)	

Part 2: Values directive

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?)

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

b) What worries me most about my future:

Refer to Part 2 b) of the instructions.

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.

Po Box 317, Cohuna 3568
Phone: 54 565 300
Fax: 54 562 627

AFFIX PATIENT LABEL HERE

U.R. NUMBER: _____

SURNAME: _____

GIVEN NAME: _____

DATE OF BIRTH: _____/_____/_____

SEX: _____

ADVANCE CARE DIRECTIVE FOR ADULTS
made under the Medical Treatment Planning and Decisions Act 2016 (Vic.)

Advance care directive of: (insert your full name)	

Part 2: Values directive (cont.)

d) Other things I would like known are:

Refer to Part 2 d) of the instructions.

Things you can include about your values and preferences are:

- spiritual, religious, or cultural requirements
- your preferred place of care
- treatment with prescription pharmaceuticals (medicine)
- treatment for mental illness
- medical research procedures.

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

Refer to Part 2 e) of the instructions.

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.	☐

Po Box 317, Cohuna 3568
Phone: 54 565 300
Fax: 54 562 627

AFFIX PATIENT LABEL HERE
U.R. NUMBER: _____
SURNAME: _____
GIVEN NAME: _____
DATE OF BIRTH: _____/_____/_____
SEX: _____

ADVANCE CARE DIRECTIVE FOR ADULTS
made under the Medical Treatment Planning and Decisions Act 2016 (Vic.)

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 is medically appropriate
- in an end-of-life care situation, certain medical interventions may be required for organ and tissue donation to take place.

a) I consent to the following medical treatment:
(Specify the medical treatment and the circumstances)

b) I refuse the following medical treatment:
(Specify the medical treatment and the circumstances)

Po Box 317, Cohuna 3568
Phone: 54 565 300
Fax: 54 562 627

AFFIX PATIENT LABEL HERE
U.R. NUMBER: _____
SURNAME: _____
GIVEN NAME: _____
DATE OF BIRTH: ____/____/____
SEX: _____

ADVANCE CARE DIRECTIVE FOR ADULTS
made under the Medical Treatment Planning and Decisions Act 2016 (Vic.)

Advance care directive of: (insert your full name)	

Part 4: Expiry date (optional)

Only complete this part if you want this advance care directive to have an expiry date. Refer to Part 4 of the instructions.

This advance care directive expires on: (dd/mm/yyyy)	

Part 5: Witnessing

You must sign in front of two adult witnesses.

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.

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

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

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

Another adult witness must complete this part of the form.

Full name of adult witness:

Signature of adult witness: Date: (dd/mm/yyyy)

Advance care directive for adults

Po Box 317, Cohuna 3568
Phone: 54 565 300
Fax: 54 562 627

AFFIX PATIENT LABEL HERE
U.R. NUMBER: _____
SURNAME: _____
GIVEN NAME: _____
DATE OF BIRTH: ____/____/____
SEX: _____

ADVANCE CARE DIRECTIVE FOR ADULTS
made under the Medical Treatment Planning and Decisions Act 2016 (Vic.)

Advance care directive of: (insert your full name)	

If an interpreter is present when this document is witnessed

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	

I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

Signature of interpreter: 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 interpreter:

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 interpreter: 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).