

## ADVANCE DIRECTIVE FOR HEALTH CARE

Name: .....

Address: .....

.....

Hospital Unit

Number: .....

It is my express wish that if I should develop:

- a) senile, severe degenerative brain disease (due to Alzheimer's disease, arterial disease, AIDS, or other agency or
- b) serious brain damage resulting from accidental or other injury or illness or
- c) advanced or terminal malignant disease or
- d) severely incapacitating and progressive degenerative disease of the nerves or muscles

and have become mentally incompetent to express my opinion about accepting or declining life sustaining treatment, and if two independent physicians conclude that, to the best of current medical knowledge, my condition is irreversible then the following points should be taken into consideration:

- In the event of a cardiac arrest, regardless of the cause, I should not be given cardiopulmonary resuscitation.
- Any separate illness – for example, pneumonia or a heart or kidney condition – that may threaten my life should not be given active treatment unless it appears to be causing me undue physical suffering.
- During such an advanced illness, if I should become unable to swallow food, fluid, or medication then these should not be given by any artificial means except to relieve obvious suffering.
- During such an illness, if my condition deteriorates without reversible cause, and as a result my behaviour becomes violent, noisy, or in other ways degrading, or if I appear to be suffering severe pain, then any such symptoms should be controlled with suitable drug treatment, regardless of the consequences on my physical health and my survival, within the extent of the law.
- Other requests.

The object of this directive is to minimise distress or indignity which I may suffer or create during an incurable illness, and to spare my medical advisers or relatives, or both, the burden of making difficult decisions on my behalf.

Signed ..... Date .....

Witness 1 .....

Witness 2.....

Statement by one witness: I ..... declare that in my opinion the above person ..... is of sound mind and understands the meaning and implications of this directive.

Signed ..... Date .....

### ADVANCE DIRECTIVE

I.....  
of.....  
advise that in any circumstance that I am not competent to make a choice about a  
future healthcare procedure, should the following situation arise:

.....  
.....  
.....

.....that I accept/decline/withdraw (delete those  
which are not applicable) the following treatment/s

.....  
.....  
.....

.....I confirm that information about the risks,  
consequences and treatment options of my decision were given (summarise below):

.....  
.....  
.....  
.....  
.....  
.....

.....Name of usual  
doctor (or Medical Practitioner with the closest relationship with the patient)

.....Signed.....(P  
atient)

Signed.....(Doctor)

Witnessed.....(Contact Person)

Date.....

Updated/reconsidered/endorsed on .....

Updated/reconsidered/endorsed on.....

Updated/reconsidered/endorsed on.....