NSW Health Advance Care Directive (ACD)

SECTION 1: YOUR DETAILS AND YOUR PERSON RESPONSIBLE

*While not legally required, it is strongly recommended that a witness co-signs this Advance Care Directive and/or a health professional witnesses you sign this form. Once completed this form is to be given to your Personal Responsible, Enduring Guardian and medical professionals. You should keep a copy in a safe place and let others know where to find it.

PERSONAL DETAILS

Family name: _____

Given names: _____

Date of birth: _____

Address: _____

_____

I have been provided with and read the 'Making an Advance Care Directive' information booklet. Please tick if yes ☐

ENDURING GUARDIAN

I have legally appointed one or more people as my Enduring Guardian/s and they are aware of this Advance Care Directive. Please tick if yes ☐

	ENDURING GUARDIAN 1	ENDURING GUARDIAN 2
Name:		
Home phone number:		
Mobile phone number:		
Email address:		

I have not appointed an Enduring Guardian ☐

PERSON RESPONSIBLE

If, because of my medical condition, I am not able to understand and make decisions about my treatment or can't tell the doctors or my family, my Person Responsible as determined according to the hierarchy within the NSW Guardianship Act (1987) is

	PERSON 1	PERSON 2
Name:		
Relationship:		
Home phone number:		
Mobile phone number:		
Email address:		

SECTION 2: PERSONAL VALUES ABOUT DYING

If you do not want to complete this section, you should sign the bottom of this section

Information about your values is important as it is not possible for this document to cover all medical situations. Information about what is important to you may help the person who is making decisions on your behalf when they are speaking to the doctors about your care and treatment.

In this section you can include:
- things that are important to you at the end of life (your beliefs and values)
- issues that worry you, and
- personal, religious or spiritual care you would like to receive when you are dying.

If I am unable to communicate and not expected to get better:
- I would like my pain and comfort managed; and
- when deciding what treatments to give to me or not to give me, I would like the person/people making health decisions for me to understand how the following would make me feel (initial the box that is your choice)

VALUES	Bearable	Unbearable (I would like treatment discontinued and to be allowed to die a natural death)	Unsure
1. If I can no longer recognise my family and loved ones, I would find life...	☐	☐	☐
2. If I no longer have control of my bladder and bowels, I would find life...	☐	☐	☐
3. If I cannot feed, wash or dress myself I would find life...	☐	☐	☐
4. If I cannot move myself in or out of bed and must rely on other people to reposition (shift or move) me, I would find life...	☐	☐	☐
5. If I can no longer eat or drink and need to have food given to me through a tube in my stomach I would find life...	☐	☐	☐
6. If I cannot have a conversation with others because I do not understand what people are saying, I would find life...	☐	☐	☐

SECTION 2: PERSONAL VALUES ABOUT DYING

If you do not want to complete this section, you should sign the bottom of this section

At the end of my life when my time comes for dying, I would like to be cared for, if possible (initial the box of your choice)

At home ☐

In a hospital ☐

Other location (e.g hospice, residential aged care – please provide details) _____ ☐

I do not know. I am happy for my Person Responsible/family to decide ☐

When my Person Responsible is making decisions about care at the end of my life, I would like them to consider the statements below

If you need extra space please attach an additional page.

I do not want to complete Section 2:

_____

(Signature)

SECTION 3: DIRECTIONS ABOUT MEDICAL CARE

If you do not want to complete this section, you should sign the bottom of this section

This section applies to when you are unable to make or communicate decisions about your health care and medical treatment, including CPR.

If you are able to communicate you will be included in decisions about your care.

Resuscitation (CPR)

CPR refers to medical procedures that may be used to try to start your heart and breathing if your heart or breathing stops. It may involve mouth to mouth resuscitation, very strong pumping on your chest, electric shocks to your heart, medications being injected into your veins and/or a breathing tube being put into your throat.

CPR
If I am not expected to recover, or if my life is unbearable as indicated in my Personal Values About Dying, Section 2 on page 2, THEN, if my heart or breathing stops (please initial one box only)

I would accept CPR ☐

OR

I would not accept CPR. Do not try to restart my heart or breathing ☐

OTHER MEDICAL TREATMENTS

If I am not expected to recover, or if my quality of life is unbearable as indicated in the table my Personal Values About Dying, Section 2 on page 2 and 3, THEN the following treatments would be UNACCEPTABLE to me (initial the box/boxes that apply to your wishes)

Artificial ventilation through a tube (also called 'life support', 'breathing machine') ☐

Renal dialysis - (kidney function replacement) ☐

Life prolonging treatments that require continuous administration of drug ☐

OTHER (e.g. food and fluid through a tube). Please list below:

Even if I am expected to get better I would never want the following medical treatments:

I do not want to complete Section 3:

_____

(Signature)

SECTION 4: SPECIFIC REQUESTS FOR ORGAN, TISSUE AND BODY DONATION

If you do not want to complete this section, you should sign the bottom of this section

ORGAN, TISSUE AND BODY DONATION

My wishes about organ, tissue and body donation for transplantation following my death are (initial your choice for each statement)

	Yes	No
I would like to donate my organs and tissues for transplantation following my death.		
I have discussed my organ and tissue donation wishes with my family and friends and they are aware of my decision.		
I would like to, or have already made arrangements to, donate my body for education and/or scientific research.		

ANTEMORTEM INTERVENTIONS FOR ORGAN DONATION

Antemortem interventions are procedures to determine, maintain or improve the viability of tissue.

Antemortem interventions for organ donation (are treatment/s immediately before my death only for the purpose of organ donation (initial the box of your choice)

	Yes	No
It is my wish to donate my organs for transplantation after my death. If I am dying, I consent to the doctors providing treatments for my **organs** before my death (including artificial ventilation, insertion of intravenous lines and administration of medications) intended only for the purpose of enabling me to donate my organs and tissue for transplantation.		

I do not want to complete Section 4:

_____

(Signature)

SECTION 5: AUTHORISATION

PERSONAL DETAILS

By signing this document, I confirm that:

- I have read the accompanying information booklet, or had the details explained to me.
- I understand the facts and choices involved, and the consequences of my decisions.
- I am aware that this Advance Care Directive will be used in the event that I cannot make or communicate my own health care decisions. If I am able to communicate, I will be asked to make decisions about my care.
- I have completed this Advance Care Directive of my own free will.

_____ ____/____/____

(Signature) (Date)

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DETAILS OF WITNESS*

I confirm that _____ signed this document on ____/____/____

Signed: _____ Name (please print): _____

Address: _____ Phone: _____

TREATING HEALTH PROFESSIONAL*

Name: _____ Designation: _____

Address: _____

Phone: _____

Email: _____

☐ I confirm that I had no reason to doubt the capacity of the person

☐ I confirm that _____ had capacity and was aware of the implications of the information in this Advance Care Directive. (Medical officer only)

_____ ____/____/____

(Signature) (Date)