

Advance Healthcare Directive – General

Explanatory Notes to the Form

Your Rights: You should clearly understand that if you are mentally competent (can participate effectively in decisions about your medical care), you have the right at any time to refuse any medical treatment that you do not want as a patient in Victoria. *If you have a specific life-threatening illness* you can formalise this by completing a *Refusal of Treatment Certificate*, available from www.dwdv.org.au. Note however that a *Refusal of Treatment Certificate* can only be signed if you have already been diagnosed with a specific illness and it applies only to refusal of treatment for *that* specific illness.

This Form: This form is a *general* advance healthcare directive that can be completed by a person of any age, in any state of health, provided that you are currently mentally competent. It stands as an expression of your wishes if you become too ill in the future to be able make your own medical treatment decisions; you are then mentally incompetent. It is designed to apply to a wide range of catastrophic illnesses that may be unforeseen but may cause you to become mentally incompetent or unable to make your treatment decisions.

This form is designed to apply to illnesses that cause severe physical or psychological suffering and/or permanent loss of independence or rational thought. It is for people who do not want the possibility that their lives will be prolonged if they become permanently and severely incapacitated due to such illnesses.

Related Advance Healthcare Directive Forms:

If you are a person who is particularly at risk, or you fear developing a specific life threatening illness, then you should *also* complete a *specific* advance directive for that particular illness. DWDV has specific advance directives for Alzheimer's and dementia, Motor Neuron Disease, HIV/AIDS, and nursing home residents. These special advance directives are available to DWDV members only.

Related Agent Form: It is also advisable to appoint an *agent* to make decisions on your behalf if you become mentally incompetent, to ensure that the Advance Healthcare Directive wishes you document in this form are followed as closely as possible. You appoint the agent using the *Enduring Power of Attorney (Medical Treatment)* form available from DWDV. The agent does *not* have to be a doctor — just someone you trust to make appropriate decisions when you can't.

How You Can Help

Dying With Dignity Victoria is a self-funded, non-profit organisation, relying on membership fees, donations and volunteers.

Ways you can help us help you:
(click links to go to our website)

- [Become a member](#)
- [Donate](#)
- [Make a bequest](#)
- [Contact politicians](#)
(we make it so easy!)
- [Share your story](#)
- [Buy from our store](#)
- [Volunteer](#)
- [Contact the media](#)

What to Do With this Form:

- You can vary the form to suit your particular view or circumstances. You must initial any options you want to include and strike out any that you don't want or that do not apply.
- Consider the 'Stipulation/s' section carefully. The second, optional stipulation is about reasoned and experienced medical opinion. If you would prefer supporting reasoned and experienced medical opinion to be a condition of refusing treatment when you are unable to participate in your own medical decisions, then tick and initial the second of the two stipulations. For example, if you were to have a minor stroke and doctors believe you have a good chance of recovery to your usual state, and you would like treatment to recover under such medical opinion, then select the second stipulation. On the other hand, if you want to refuse treatment regardless of doctors' opinion of your likely recovery, strike out the second stipulation so that it does not apply.
- *Your regular doctor should sign the form in Attachment B. Take this opportunity to discuss the form with your doctor and have her or him explain anything you are unclear about.*
- The form should be renewed regularly, say every 5 years when you are younger, but more frequently as you get older particularly if you are diagnosed with a serious illness. Renewing it provides a valuable opportunity for you to re-emphasise your views to your doctor and family.
- Your agent and family should also be made aware of this document and have copies. Copies of this document should be given to your regular doctor and any other doctor who is treating you for a serious illness. If you are entering a hospital, hospice or other healthcare facility, give the facility a copy to be placed in your medical file.

This document has legal status in common law and your doctor should abide by it in the circumstances that are described in the document. (The document would have greater power if it had the protection of *statute* law. DWDV is working with professional medical bodies and the Victorian Parliament to achieve this reform.)

See the separate DWDV document 5a (*example*) for an illustration of a completed General Advance Directive. It may help you further understand how to correctly indicate your wishes.

Advance Healthcare Directive – General

**TO MY FAMILY, MY PHYSICIAN AND ALL OTHER PERSONS CONCERNED,
THIS DIRECTIVE is made after careful consideration by me:**

(Name).....
of

.....

.....(Address)
at a time when I am rational and of sound mind.

STIPULATION/S:

This Advance Healthcare Directive applies only if the following stipulation/s are met:

- If at any time I have become unable to participate effectively in decisions about my medical care.
- If two independent doctors (at least one a specialist) are of the opinion that I am unlikely to recover from a severe illness to a state of independence and competence, or that such recovery could only be to a state of profound physical or psychological suffering. Such an illness could include severe and lasting brain injury or dementia.
(If you want the second stipulation above to apply, tick and initial it. If you *don't* want it to apply, strike through its entire paragraph and initial at the end of the paragraph.)

**IF THE STIPULATION/S ARE MET, THEN IN THOSE CIRCUMSTANCES I DECLARE
that I am not to be subjected to any medical intervention or treatment aimed at prolonging
or sustaining my life, AND QUITE SPECIFICALLY:**

(For each treatment, *Initial* the column choice *that reflects your wishes*):

Treatment	I <u>DON'T</u> want	I want	Treatment	I <u>DON'T</u> want	I want
Artificial feeding (nutrition and/or hydration)			Corrections of abnormal levels of any toxic substance		
Antibiotics			Blood transfusion		
Artificial respiration			Drug treatment of hi/lo blood sugar		
<u>Any</u> surgical procedures			Drug treatment of hi/lo blood pressure		
Circulatory support including CPR			Renal dialysis		

(Once you have initialled one of the choices for each treatment, draw a simple diagonal stroke, / through each of the unsigned choice boxes so that none is left unmarked.)

AND, again where the stipulation/s apply, any persistent Distressing Symptoms are to be *maximally palliated* by appropriate analgesic, sedative or other palliative treatment, even though that palliative treatment may also have the additional consequence of shortening my life, AND QUITE SPECIFICALLY:

(For each Distressing Symptom, *Initial* the column choice *that reflects your wishes*):

Distressing Symptom	<u>Maximum Palliation</u>	Not Maximum Palliation	Distressing Symptom	<u>Maximum Palliation</u>	Not Maximum Palliation
Pain			Those caused by lack of food & fluid		
Breathlessness			Psychological suffering such as fear, panic, terror, extreme anxiety or delirium.		
Extreme weakness or paralysis leading to total dependence			Loss of appetite, nausea, vomiting, diarrhoea or incontinence.		

(Once you have initialled one of the choices for each distressing symptom, draw a simple diagonal stroke, / through *each of the unsigned choice boxes* so that none is left unmarked.)

AND, again where the stipulation/s apply, if it should be legal to do so at that time, I request that my death be hastened by a doctor providing or administering a fatal dose to allow me to die with dignity.

I wish it to be understood that I dread degeneration, prolonged dependence, inability to communicate and indignity far more than I fear death. I ask my medical attendants to bear this statement in mind when considering what my intentions would be in any uncertain situation. I hereby absolve my medical attendants from any civil liability arising from compliance with this Advance Healthcare Directive.

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

SIGNED BY ME: (*Signature*)

this day of..... 20.....

in the presence of (*Signature of Witness*)

(*Name & address*)

(*of witness*)

.....

Attachment A: Your Health Status at Time of Signing

At the time of signing this document,

<i>(Tick and initial the one that applies.)</i>	Initials
<input type="checkbox"/> I am in good health	
<input type="checkbox"/> I have been advised that I am suffering from: <i>(Write in the diagnosis.)</i>	

Attachment B: Your Medical Practitioner to Sign Here

I, *(Medical Practitioner's name),*

of *(address of Medical Practitioner)*

attest that *(patient's name),* is of sound mind.

Medical Practitioner's Signature: Date:

Attachment C: Your Chosen Appointed Agent

<i>(Tick and initial the one that applies.)</i>	Initials
<input type="checkbox"/> I have completed an Enduring Power of Attorney (Medical Treatment) form and appointed the following person as my agent: <i>(name of agent)</i> of <i>(address of agent)</i>	
<input type="checkbox"/> I have <i>not</i> completed an Enduring Power of Attorney (Medical Treatment) form and have not appointed anyone as my agent.	

Attachment D: Organ Donation

In the event of my death,

<i>(Tick and initial the one that applies.)</i>	Initials
<input type="checkbox"/> I want to donate my organs for transplantation	
<input type="checkbox"/> I do <i>not</i> want to donate my organs for transplantation	