**End of Life Care – Advance Care Directive**

Section 1

|  |  |  |
| --- | --- | --- |
| Family name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Given name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 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:** |  |  |
| **Phone Number:** |  |  |
| **Email Address:** |  |  |

Section 2

|  |
| --- |
| *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 you do not want to complete this section, you should sign the bottom of the section on page 3*  *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**  *(cease treatment & die a natural death)* | **Unsure** |
| 1. If I can no longer recognise my family and loved ones, I would find life… |  |  |  |
| 1. If I no longer have control of my bladder and bowels, I would find life… |  |  |  |
| 1. If I cannot feed, wash or dress myself I would find life… |  |  |  |
| 1. 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… |  |  |  |
| 1. 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… |  |  |  |
| 1. If I cannot have a conversation with others because I do not understand what people are saying, I would find life… |  |  |  |
| 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 hospital  Other location (hospice, residential care)  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.  Signed: | | | |

Section 3

|  |
| --- |
| *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.*  *If you do not want to complete this section, you should sign the bottom of this section* |
| Cardio Pulmonary 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 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **How I would like to spend my last days:** | | | | |
| **Importance to me** | **High** | **Medium** | **Low** | **Not Important** |
| Avoiding pain and suffering, even if it means that I might not be awake or continue living |  |  |  |  |
| Being alert, even if it means I might be in pain and discomfort |  |  |  |  |
| Having religious or spiritual advisors at my side when I die |  |  |  |  |
| Reconciling differences and saying ‘good-bye’ to my family and friends |  |  |  |  |
| Being kept alive long enough for my family to see me before I die, even if I am unconscious |  |  |  |  |
| Being allowed to die naturally in a place with my preference of music, aroma, taste and touch |  |  |  |  |
| 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) | | | | |

Section 4