ADVANCE HEALTH CARE DIRECTIVE

This form deals with your future health care.

The time may come when you cannot speak for yourself. By completing this form, you can give directions about what medical treatment you would want, or not want, at such a time.

Acknowledgement

This Advanced Health Care Directive has been developed by Professor Colleen Cartwright, Director, Aged Services Learning and Research Collaboration Southern Cross University, Coffs Harbour. The document was originally developed for use under the Queensland Powers of Attorney Act 1998 and is part of that legislation. Professor Cartwright has written the document to reflect NSW law.

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EXPLANATORY NOTES

Every competent adult has the legal right to accept or refuse any recommended health care. This is relatively easy when people are well and can speak for themselves.

Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes - at the very time when many critical decisions need to be made.

By completing this Advance Health Care Directive, you can make your wishes known before this happens.

What is an Advance Health Care Directive?

An Advance Health Care Directive is a document that states your wishes or directions regarding your future health care for various medical conditions. It comes into effect *only* if you are unable to make your own decisions.

You may wish your directive to apply at any time when you are unable to decide for yourself, or you may want it to apply only if you are terminally ill.

Can anyone make an Advance Health Care Directive?

Yes, anyone who is over eighteen years of age and is capable of understanding the nature of their directions and foreseeing the effects of those directions can generally make an Advance Health Care Directive.

What do I need to consider before making an Advance Health Care Directive?

You should think clearly about what you would want your medical treatment to achieve if you become ill. For example:

- If treatment could prolong your life, what level of quality of life would be acceptable to you?
- How important is it to you to be able to communicate with family and friends?
- How will you know what technology is available for use in certain conditions?

It is strongly recommended that you discuss this form with your doctor before completing it and also ask your doctor to complete Section 7 of the form.

The purpose of an Advance Health Care Directive is to give you confidence that your wishes regarding health care will be carried out if you cannot speak for yourself. However, a request for euthanasia would not be followed, as this would be in breach of the law. It is a criminal offence to accelerate the death of another person by an act or omission. It is also an offence to assist another person to commit suicide.

Can I cover all possible health-care decisions in this form?

No, it would not be possible to anticipate everything. However, if you wish, you can appoint someone to have Enduring Guardianship for you; this person can then make decisions on your behalf about your health-care and other personal matters if you are no longer able to do so.

If you have already given someone Enduring Guardianship, all you need to do is discuss this directive with that person and complete Section 8 when you come to it.

If you have **not** yet appointed anyone and you wish to do so, you will need to complete an Appointment of Enduring Guardian form and have a lawyer or a registrar of the local court witness you, and your Enduring Guardian, signing the form. (NOTE: the signatures can be witnessed by different witnesses at different times).

You may also wish to give someone Enduring Power of Attorney for financial matters in case you need someone to manage your property or money, e.g. if you are in a nursing home. If you wish to do that, you will need to complete a separate Enduring Power of Attorney form.

Can I change or revoke my Advance Health Care Directive?

Yes, your wishes as stated in an Advance Health Care Directive are not final; you can change them at any time while you remain mentally capable of doing so.

It is wise to review your directive every two years or if your health changes significantly.

If you do want to make major changes to your directive, you should destroy the current one and make a new one. If you make minor changes, make sure you sign and date alongside the change.

You may also totally revoke your directive at any time. This should be done in writing, so that you can give a copy to anyone who has a copy of your current Advance Health Care Directive, but no specific form is required and the person witnessing your signature does **not** need to be a justice of the peace or a lawyer.

Where can I get help with my Advance Health Care Directive?

As your doctor should complete Section 7 of this document, you could ask him/her to help you. Your doctor could explain any medical terms or other words that you are unclear about. You may also wish to discuss your decisions with family members or close friends.

Who is involved in completing this document?

At least three people:

- **You, as the principal**. (You are referred to as the principal because you are the person principally involved.) You complete Sections 1 to 6, Section 8 and Section 9.

- **A doctor** who completes Section 7 (you also sign that Section).

- **Your witness** who completes Section 10. Your witness should be a justice of the peace or a lawyer. He/she should not be your Enduring Guardian, a relation of yours or of your Enduring Guardian, a beneficiary under your will, your current paid carer or your current health-care provider (e.g. nurse or doctor). Your witness and the doctor who signs Section 7 do not have to sign the document on the same date, but your doctor should sign it first.

  Note: *'Paid carer' does not mean someone receiving a carer's pension or similar benefit, so you are free to choose someone who is receiving such a benefit for looking after you.*

What do I do with the completed document?

You should keep it in a safe place, and you should give a copy to your own doctor, to your Enduring Guardian if you have appointed one, to a family member or friend and, if you wish, to your solicitor.

If you are admitted to hospital or to a residential aged care facility (RACF – previously called a hostel or a nursing home), make sure the hospital or RACF staff know that you have an Advance Health Care Directive and either give them a copy of it or tell them where a copy can be obtained.

You may also wish to carry a card in your purse or wallet stating that you have made a Directive, and where it can be found.

How often should I update my Advance Health Care Directive?

It is strongly recommended that you review the document every two years, or if/when there is a major change in your health status (e.g. if you are diagnosed with a serious illness or if you are admitted to a RACF). If you **do not** wish to make any changes, simply sign and date one part of Section 11. If you **do** want to make major changes, you will need to complete a new document.

SECTION 1: YOUR DETAILS

It is strongly recommended that, before completing this document, you discuss it with your general practitioner or a specialist medical practitioner who knows your medical history and views. The doctor will then be able to explain any medical terms that you are unsure about and will also be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decisions you have made in the document. You can then ask this doctor to complete and sign Section 7 of the document. You must also sign that Section, as well as Section 9.

Complete this section by writing on the lines.

TO MY FAMILY, FRIENDS AND HEALTH-CARE PROVIDERS

1. I,____

[Print your full name here]

of ____

[Print here the number of your house, name of your street and suburb]

State: ____ Postcode:____________

[Print here the name of the State where you live]

born on____

[Print here the date of your birth]

being over the age of eighteen years, make this directive after careful consideration and of my own free will.

If at any time I am unable to take part in decisions about my medical care, let this document stand as evidence of my views, wishes and beliefs about my quality of life and the medical treatment I require.

This directive should never be used if I have the capacity to speak competently for myself or if there is evidence that it has been revoked.

I sign this document in the full knowledge that my health care may be limited as a result, but only as specified below.

I request that all who are responsible for my care respect the directions given in this document.

SECTION 2: GENERAL INSTRUCTIONS

(Complete this section by ticking the appropriate boxes and writing on the lines.)

2. If I temporarily lose capacity and am unable to give directions for my health care because of injury or illness, I want my health-care providers to give me:

☐ all available treatment
☐ all available treatment except for:

____

____

____

____

[Use these lines to describe any treatment you would not want to have in any circumstances]

3. Are there any special conditions that your health-care providers should know about, such as asthma or any allergy to medication?

☐ No - ***Go to 5 (below)***
☐ Yes.

4. Describe these special conditions here *(for example 'I develop a severe rash when given penicillin' or 'I have insulin-dependent diabetes')*:

____

____

____

[Use these lines to write descriptions of any special conditions]

5. Do you have any religious beliefs that may affect your treatment?

☐ No - ***Go to Section 3***
☐ Yes.

6. Describe here how your religious beliefs might affect your treatment *(for example: 'Because of my religious beliefs, I do not want to receive any blood transfusions or organ transplants')*:

____

____

____

[Use these lines to describe how your religious beliefs might affect your medical treatment]

SECTION 3: TERMINAL, INCURABLE OR IRREVERSIBLE CONDITIONS

Definitions of terms used in this section

- **terminal**: resulting in death—the patient can reasonably be expected to die within the next twelve months, and this prognosis has been confirmed by a second medical practitioner.
- **incurable**: no known cure.
- **irreversible**: unable to be turned around—there is no possibility that the patient will recover. An example of an irreversible illness is Motor Neurone Disease, which progressively paralyses the body.
- **permanent unconsciousness (coma)**: when brain damage is so severe that there is little or no possibility that the patient will regain consciousness.
- **persistent vegetative state**: severe and irreversible brain damage, but vital functions of the body continue (e.g. heart beat and breathing).
- **palliative care**: treatment that is not aimed at a cure but at caring for the patient by keeping him/her as physically comfortable and pain-free as possible, while also attending to his/her emotional, mental, social and spiritual needs.

Life-sustaining measures

These include:

- **cardiopulmonary resuscitation**: emergency measures to keep the heart pumping (by massaging chest or using electrical stimulation) and artificial ventilation (mouth-to-mouth or ventilator) when breathing and heart beat have stopped.
- **assisted ventilation**: use of a machine, such as a ventilator, to help the patient breathe when he/she is unable to breathe unaided.
- **artificial feeding and hydration:** provision of food and fluid by artificial means when the patient is unable to eat or drink. This may be done by passing a tube through the nose into the stomach or by inserting a tube into a vein or directly into the stomach. (If you do not have artificial feeding, your mouth will still be kept moist.)

If you are extremely ill, you may be treated by someone who is not your usual doctor. This person is referred to as **your treating medical practitioner**.

The directions you give in this section apply *only* if, in the opinion of your treating medical practitioner:

- you have a terminal, incurable, or irreversible illness or condition,
- or you are in a persistent vegetative state,
- or you are permanently unconscious,
- or you are so seriously ill or injured that you are unlikely to recover to the extent that you can survive without the continued use of life-sustaining measures.

Complete this section by:

- first considering the points carefully,
- then ticking the boxes next to the points that you want to apply to you,
- then writing your initials on the lines that follow those points,
- and finally, drawing a line across any part that you do not want to apply to you.

7. I request that:

☐ everyone responsible for my care initiate *only* those measures that are considered necessary to maintain my comfort and dignity, with particular emphasis on the relief of pain.

____
[Initial here]

☐ any treatment that might obstruct my natural dying either not be initiated or be stopped.

____
[Initial here]

☐ unless required for my dignity and comfort as part of my palliative care, no surgical operation is to be performed on me.

____
[Initial here]

8. If I am in the terminal phase of an incurable illness:

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:*__________
☐ I **do** want cardiopulmonary resuscitation. *Initial here:*__________

☐ I **do not** want assisted ventilation. *Initial here:*__________
☐ I **do** want assisted ventilation. *Initial here:*__________

☐ I **do not** want artificial hydration. *Initial here:*__________
☐ I **do** want artificial hydration. *Initial here:*__________

☐ I **do not** want artificial nutrition. *Initial here:*__________
☐ I **do** want artificial nutrition. *Initial here:*__________

☐ I **do not** want antibiotics. *Initial here:*__________
☐ I **do** want antibiotics. *Initial here:*__________

Other treatment (specify):

☐ I **do not** want ______________________________ *Initial here:*__________
☐ I **do** want __________________________________ *Initial here:*__________

9. If I am permanently unconscious (in a coma):

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:*__________
☐ I **do** want cardiopulmonary resuscitation. *Initial here:*__________

☐ I **do not** want assisted ventilation. *Initial here:*__________
☐ I **do** want assisted ventilation. *Initial here:*__________

☐ I **do not** want artificial hydration. *Initial here:*__________
☐ I **do** want artificial hydration. *Initial here:*__________

☐ I **do not** want artificial nutrition. *Initial here:*__________
☐ I **do** want artificial nutrition. *Initial here:*__________

☐ I **do not** want antibiotics. *Initial here:*__________
☐ I **do** want antibiotics. *Initial here:*__________

Other treatment (specify):

☐ I **do not** want ______________________________ *Initial here:*__________
☐ I **do** want __________________________________ *Initial here:*__________

10. If I am in a persistent vegetative state

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:*__________
☐ I **do** want cardiopulmonary resuscitation. *Initial here:*__________

☐ I **do not** want assisted ventilation. *Initial here:*__________
☐ I **do** want assisted ventilation. *Initial here:*__________

☐ I **do not** want artificial hydration. *Initial here:*__________
☐ I **do** want artificial hydration. *Initial here:*__________

☐ I **do not** want artificial nutrition. *Initial here:*__________
☐ I **do** want artificial nutrition. *Initial here:*__________

☐ I **do not** want antibiotics. *Initial here:*__________
☐ I **do** want antibiotics. *Initial here:*__________

Other treatment (specify):

☐ I **do not** want ____________________________ *Initial here:* _____________
☐ I **do** want ________________________________ *Initial here:* _____________

11. If I am so seriously ill or injured that I am unlikely to recover to the extent that I can live without the use of life-sustaining measures:

☐ I **do not** want cardiopulmonary resuscitation. *Initial here:*__________
☐ I **do** want cardiopulmonary resuscitation. *Initial here:*__________

☐ I **do not** want assisted ventilation. *Initial here:*__________
☐ I **do** want assisted ventilation. *Initial here:*__________

☐ I **do not** want artificial hydration. *Initial here:*__________
☐ I **do** want artificial hydration. *Initial here:*__________

☐ I **do not** want artificial nutrition. *Initial here:*__________
☐ I **do** want artificial nutrition. *Initial here:*__________

☐ I **do not** want antibiotics. *Initial here:*__________
☐ I **do** want antibiotics. *Initial here:*__________

Other treatment (specify):

☐ I **do not** want ____________________________ *Initial here:*__________
☐ I **do** want ________________________________ *Initial here:*__________

SECTION 4: RESIDENTIAL CARE (OPTIONAL SECTION)

On this page you may record your wishes for care or treatment that you want, or do not want, if you are ever living in a Residential Aged Care Facility (RACF). (Note: Residential Aged Care Facilities were previously called hostels or nursing homes).

If you are currently living in a RACF it is strongly suggested that you complete this Section **now.** If you are *not* currently living in a RACF you may still choose to complete this Section but you should review it if, at some future time, you do become a resident in a RACF.

If you are living in a RACF, it is highly likely that you are no longer able to live independently in the community, and you require assistance with activities of daily living, such as toileting, showering and dressing, or getting in and out of bed, or perhaps eating. For older people, this usually happens towards the end of life, perhaps as a result of on-going or chronic illness and/or increasing frailty.

Despite needing assistance with basic activities, you may still find life interesting and enjoyable, take pleasure in visits from family or friends, or enjoy listening to music, watching television or eating nice food. However, there may come a time when you feel that your quality of life is no longer acceptable to you and at this time you may prefer that the focus of your care be on maintaining your comfort and dignity, while minimising your suffering. The care required to achieve these goals can usually be well managed by the nursing staff in the RACF and your General Practitioner.

Question 12 provides a list of conditions that some people would consider unacceptable. Not everyone will have the same list. Read through the list, and circle the number that matches how much you agree or disagree with the statement. You may also add anything else that you would consider to be unacceptable for a good quality of life in a RACF.

12. To what extent do you agree that the following levels of functioning would be unacceptable to you? (Please circle one number for each statement)

1 = Strongly Agree; 2 = Agree; 3 = Neither Agree nor Disagree; 4 = Disagree; 5 = Strongly Disagree

Level of Function	SA	A	N	D	SD
(a) not being able to recognise people who are important to you	1	2	3	4	5
(b) not being able to communicate	1	2	3	4	5
(c) not being able to eat by mouth	1	2	3	4	5
(d) not having control of your bladder and bowels	1	2	3	4	5
(e) Other -1 (Please specify) ……………………….. ………………………………………………………	1	2	3	4	5
(f) Other -2 (Please specify) ………………………... ……………………………………………………….	1	2	3	4	5

13. If you were in a RACF, and your condition included a level of functioning that you have said would be unacceptable to you, would you prefer to be kept comfortable in the RACF or would you rather go to hospital, if you experienced any of the following conditions (remember, your Advance Health Care Directive will only be used if you can no longer speak for yourself):

(Please circle one number on each line)		**Stay in RACF**	**Go to Hospital**
(a)	a severe chest infection	1	2
(b)	breathing difficulties	1	2
(c)	pain that was difficult to control	1	2
(d)	a broken bone (e.g. arm or hip)	1	2
(e)	a urinary tract infection	1	2
(f)	chest pain	1	2

END-OF-LIFE/PALLIATIVE CARE

End-of -life care refers to the care provided to people who are dying and is sometimes called palliative care. Palliative care is care that does not seek to cure but aims to maintain comfort and dignity, and to minimise suffering. End-of-life care can usually be provided in the RACF, by the nurses you know and your General Practitioner. Alternatively, your end-of-life care could be provided in a local hospital. This would require that you be transferred to hospital in an ambulance and admitted to the ward via the Emergency Department. The way in which your end-of-life care is managed should be the same, whether you are in the RACF or if you go to hospital. However, what will be different will be whether you require transportation to hospital, the location of care and the staff who provide the care.

14. If you were in a RACF and could no longer speak for yourself, and you had reached a stage where you required end-of-life care (palliative care), would you prefer to remain in the RACF or would you prefer to be transferred to hospital?

(Please circle one number only)		**Stay in RACF**	**Go to Hospital**
(a)	Preferred place for end-of-life care	1	2

Note: If you choose **not to** complete this section, please draw a line through both pages before you sign the document. If at a later stage you are admitted to a RACF you may wish to complete a new Advance Health Care Directive, including this Section.

SECTION 5: TISSUE DONATION

You may use this form to authorise tissue donations for purposes referred to in the Human Tissue Act 1983. (Note: "Tissue" includes organs such as kidneys or heart). These purposes are the transplantation of the tissue to the body of a living person or the use of the tissue for other therapeutic purposes or for other medical or scientific purposes.

Although you may have said, in clauses 7-11 of this Directive, that you do not want to be kept alive by life-support systems under the circumstances listed in those clauses, it may be necessary to do so in order to allow you to donate your tissue/organs.

14. Have you given consent for the removal of your tissue/organs after death? (e.g. on your driver's licence or any other tissue/organ donation form)

☐ No
☐ Yes - ***Go to Q 16, below.***

15. Do you want to consent to the removal of your tissue/organs after death? (e.g. on your driver's licence or any other tissue/organ donation form)

☐ No - ***Go to section 6.***
☐ Yes.

16. I agree that, if necessary for tissue donation, life support systems such as assisted ventilation may be continued. In all other circumstances, my wishes as listed in clauses 7-11 are to be respected.

____
[principal signs here]

.

SECTION 6: PERSONAL STATEMENT

If you have any specific views about particular types of health care or special health matters that have not already been covered in this directive, you can record them in this section. It is recommended that you discuss this section with your doctor before completing it, as it is important that anything you write should be readily understood by medical staff who are treating you.

It is your legal right to refuse any medical treatment. However, you may not be entitled to insist on receiving a particular treatment (for example, if your doctor's professional opinion is that the treatment would not be of benefit to you).

17. Do you have any particular wishes about your health care other than those listed in Sections 2 and 3?

☐ No - ***Go to Q19 (below).***
☐ Yes.

18. Record your wishes here. *(For example, you may wish to write something similar to the following: 'I value life, but not under all conditions. I consider dignity and quality of life to be more important than mere existence' or 'I request that I be given sufficient medication to control my pain, even if this hastens my death'.)*

____

____

____

____

19. Do you wish to specify anyone who is *<u>not</u>* to be contacted about your treatment?

☐ No - ***Go to Section 7.***
☐ Yes.

20. List here the names of any people who are *not* to be contacted about your treatment:

____

____

____

SECTION 7 – DOCTOR INVOLVEMENT

It is strongly recommended that, before completing this document, you discuss it with your general practitioner or a specialist medical practitioner who knows your medical history and views. The doctor will then be able to explain any medical terms that you are unsure about and will also be able to state that you were not suffering from depression or any other condition that would affect your ability to understand the decisions you have made in the document.

After the doctor signs this section, it is strongly recommended that you ask an independent witness (such as a Justice of the Peace or a Lawyer) to sign Section 10 - this does not have to be done on the same day.

21. Doctor's name:____

Doctor's address: ____

____ Postcode: ___________

Doctor's telephone number:____

22. Statement of nominated doctor

(a) I have discussed this document with the principal and, in my opinion, he/she is not suffering from any condition that would affect his/her capacity to understand the things necessary to make this directive, and he/she understands the nature and likely effect of the health care described in this document, and

(b) (*tick one box only)*

- ☐ the principal signed this part of this document in my presence,
- ☐ in my presence, the principal instructed another person to sign this part of this for the principal, and the person signed it in my presence and in the presence of the principal,

(c) I am not

- the person witnessing this Advance Health Care Directive
- or the person signing the Advance Health Care Directive for the principal
- or an Enduring Guardian of the principal
- or a relation of the principal or of an Enduring Guardian of the principal
- or a beneficiary under the principal's will.

x___________________________ *[Principal signs here]*

x___________________________ *[Doctor signs here]*

___________________________ *[Doctor writes the date here]*

23. If this directive is ever required for your medical care, do you want the doctor named above (Clause 21) to be consulted by your treating medical practitioner?

- ☐ Yes.
- ☐ No.

SECTION 8: ENDURING GUARDIANSHIP

If you have appointed someone as your Enduring Guardian, complete this Section so that your Health Care Provider knows who can make decisions on your behalf about what health care is to be used in situations that are not dealt with explicitly in this form (except for 'special health' matters).

It is important to discuss with your Enduring Guardian/s your views and wishes regarding your health care as you have set them down in this directive so that any decisions he/she/they may make on your behalf will accord with your wishes.

Note: Only Enduring Guardian matters made since the Guardianship Act 1987 was amended are valid. Powers of Attorney for **financial** matters made before that date may be valid.

24. Have you completed the "Appointment of Enduring Guardianship" form?

☐ No - ***Go to Section 9.***
☐ Yes.

25. In that document, who did you appoint to make decisions for you in relation to personal/health matters?

Print your Enduring Guardian's name, address and telephone number here:

Enduring Guardian's Name:____

Enduring Guardian's Address:____

____

Enduring Guardian's telephone number: (work) ________________(home)_____________

26. Did you appoint more than one Enduring Guardian?

☐ No - ***Go to 28.***

☐ Yes

Print the name/s, address/es and telephone number/s of your other Enduring Guardian/s here:

Second Enduring Guardian's name: ____

Second Enduring Guardian's address:____

____

Second Enduring Guardian's telephone number: (work) ___________ (home) ___________

*[If you do not have a **third** Enduring Guardian, cross these lines out]*

Third Enduring Guardian's name: ____

Third Enduring Guardian's address: ____

____

Third Enduring Guardian's telephone number: (work) ___________(home)___________

27. How did you decide that your Enduring Guardians would make their decisions?

(Tick one box only)

- ❑ Severally (any one of them may decide)
- ❑ Jointly (unanimously)
- ❑ As a majority (if you are appointing more than three Enduring Guardians, please specify (e.g. 'Simple majority'; 'Two-thirds majority'):

____

Other:____

28. If I lose the capacity to make health-care decisions for myself and the directions in this Advance Health Care Directive are inadequate for any reason, I understand that an Enduring Guardian can make decisions about health matters for me.

x_________________________________

[Principal signs here]

SECTION 9: STATEMENT OF UNDERSTANDING AND SIGNATURE

This statement declares that you fully understand the directions you have given. Read through it carefully, and then sign on the line that follows.

To give the document better legal status, you should sign the document in front of a qualified witness—that is, someone who is a Justice of the Peace, or a lawyer. The witness should not be your Enduring Guardian, a relation of yours or of your Enduring Guardian, your current paid carer or your current health-care provider.

Note: ‘Paid carer’ does not mean someone receiving a carer’s pension or similar benefit.

If you are not physically able to sign for yourself, you may have another person sign the document on your behalf, but you must be in the presence of the witness when you instruct that person to sign for you and when he/she actually signs. He/she must be at least 18 years old and must not be the witness to this document or your Enduring Guardian. Any person who signs on your behalf should print his/her name and designation (e.g. nurse, doctor, neighbour, daughter) in the space indicated, tick the boxes, and then sign the statement with his/her own signature.

29. I understand:

- ❑ the nature and the likely effects of each direction stated in this directive;
- ❑ that a direction operates only while I have impaired capacity for the matter covered by the direction;
- ❑ that I may change or revoke a direction in the directive at any time where I have the capacity to make a decision about the matter covered by the direction;

X___________________________________ ______________________________
[Principal signs here] *[Witness signs here]*

_______/________/20_____
[Witness writes the date here]

<u>or</u>

If you are signing for principal:

I, ____ , state that:
[print your full name here]

(a) I am at least 18 years old
(b) I am not a witness for this Advance Health Care Directive or an Enduring Guardian for the principal.

X_____________________________ _______/________/20____
[Person signing for the principal signs here] *[Write the date here]*

X_______________________________________ _______/________/20_____
[Witness signs here] *[Witness writes the date here]*

SECTION 10: WITNESS'S CERTIFICATE

IMPORTANT NOTICE TO THE WITNESS

Your role goes beyond ensuring that the signature of the principal (the person making the directive) is genuine. You certify that the principal appeared to understand the matters stated in Clause 29. In the future, you may have to provide information about the principal's capacity to understand these matters when making the directive. If you are doubtful about the principal's capacity, you should make the appropriate inquiries, e.g. from the principal's doctor.

It is strongly recommended that, if you are in any doubt, you make a written record of the proceedings and of any questions you asked to determine the principal's capacity.

As witness, you complete this section by writing on the lines and ticking the appropriate boxes.

30. I, ____, state that:
[Print your full name here]

a) I am at least 21 years of age;

b) I am a Justice of the Peace/Lawyer/Notary Public; *(cross out whichever do not apply)*

c) I am not an Enduring Guardian for the principal or a relation of the principal, or a relation of the principal's Enduring Guardian (if any) or a beneficiary under the principal's will or a current paid carer or health-care provider for the principal. *(**Note**: 'Paid carer' does not mean someone receiving a carer's pension or similar benefit.)*

d) I have verified that Section 7 of this document has been signed and dated by a doctor.

e) (*Tick one box only)*

❑ the principal signed this directive in my presence
❑ in my presence, the principal instructed another person to sign for the principal,
❑ and the person signed it in my presence and in the presence of the principal,

and

f) ❑ at the time that this directive was signed, the principal appeared to me to understand the matters stated in Clause 29 (and Clause 28 if applicable).

X________________________________
[Witness signs here]

SECTION 11: REVIEW OF THIS DOCUMENT

It is strongly recommended that you regularly review this document, as your wishes may change or there may be advances in medical technology. You would be wise to review the document every two years or if the state of your health changes significantly.

Each time you review your document and your wishes have not changed, sign and date one of the acknowledgments below. If your wishes have changed a great deal, you should complete a new document.

REVIEW OF DOCUMENT: 1

I affirm that I have reviewed this document and that there is nothing I would like to change.

*Signature:*____

Date: ___________________20____.

REVIEW OF DOCUMENT: 2

I affirm that I have reviewed this document and that there is nothing I would like to change.

*Signature:*____

Date: ___________________20____.

REVIEW OF DOCUMENT: 3

I affirm that I have reviewed this document and that there is nothing I would like to change.

*Signature:*____

Date: ___________________20____.