ADVANCE DIRECTIVE

Section 1: Personal details of the maker of this advance directive

Name: _____ (Note: Please use capital letters)

Identity Document No.:

Gender: Male / Female

Date of Birth: _____/ _____/ _____

(Day) (Month) (Year)

Contact Address:

Home Telephone No.:

Office Telephone No.:

Mobile phone No.:

Section 2: Background

1. I understand that the object of this directive is to minimise distress or indignity which I may suffer or create when I am terminally ill or in a persistent vegetative state or a state of irreversible coma, and to spare my medical advisers or relatives, or both, the burden of making difficult decisions on my behalf.

2. I understand that euthanasia will not be performed, nor will any unlawful instructions as to my medical treatment be followed in any circumstances, even if expressly requested.

3. I, _____ *(please print name)* being over the age of 18 years, revoke all previous advance directives made by me relating to my medical care and treatment (if any), and make the following advance directive of my own free will.

4. If I become terminally ill or if I am in a state of irreversible coma or in a persistent vegetative state as diagnosed by my attending doctor and at least one other doctor, so that I am unable to take part in decisions about my medical care and treatment, my wishes in relation to my medical care and treatment are as follows:

(Note: Complete the following by ticking the appropriate box(es) and writing your initials against that/those box(es), and drawing a line across any part you do not want to apply to you.)

(A) Case 1 – Terminally ill

(Note: In this instruction –

> *"terminally ill" means suffering from advanced, progressive, and irreversible disease, and failing to respond to curative therapy, having a short life expectancy in terms of days, weeks or a few months; and the application of life-sustaining treatment would only serve to postpone the moment of death, and "life-sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration. (Artificial nutrition and hydration means the feeding of food and water to a person through a tube.))*

□ **Save for basic and palliative care, I do not consent to receive any life-sustaining treatment. Non-artificial nutrition and hydration shall, for the purposes of this form, form part of basic care.**

□ **However, I want to continue to receive artificial nutrition and hydration, if clinically indicated, until death is imminent and inevitable.**

I do not want to be given the following treatment:

□

□

(B) Case 2 – Persistent vegetative state or a state of irreversible coma

(Note: In this instruction –

> *"life-sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration. (Artificial nutrition and hydration means the feeding of food and water to a person through a tube.))*

□ **Save for basic and palliative care, I do not consent to receive any life-sustaining treatment. Non-artificial nutrition and hydration shall, for the purposes of this form, form part of basic care.**

□ **However, I want to continue to receive artificial nutrition and hydration, if clinically indicated, until death is imminent and inevitable.**

I do not want to be given the following treatment:

□

□

5. I make this directive in the presence of the two witnesses named in Section III of this advance directive, who are not beneficiaries under:

(i) my will; or

(ii) any policy of insurance held by me; or

(iii) any other instrument made by me or on my behalf.

_____ _____

Signature of the maker of this advance directive **Date**

Section 3: Witnesses

<u>Notes for witness:</u>

A witness must be a person who is not a beneficiary under –

(i) the will of the maker of this advance directive; or

(ii) any policy of insurance held by the maker of this advance directive;

or

(iii) any other instrument made by or on behalf of the maker of this advance directive.

Statement of Witnesses

First Witness

(Note: This witness must be a registered medical practitioner, who, at the option of the maker of this directive, could be a doctor other than one who is treating or has treated the maker of this directive.)

(1) I, _____ *(please print name)* sign below as witness.

(a) as far as I know, the maker of this directive has made the directive voluntarily; and

(b) I have explained to the maker of this directive the nature and implications of making this directive.

(2) I declare that this directive is made and signed in my presence together with the second witness named below.

_____ _____

(Signature of 1st witness) **(Date)**

Name:

Identity document No. / Medical Council Registration No.

Office address:

Office Tel. No.:

Second witness

(Note: This witness must be at least 18 years of age)

(1) I, _____ *(please print name)* sign below as a witness.

(2) I declare that this directive is made and signed in my presence together with the first witness named above, and that the first witness has, in my presence, explained to the maker of this directive the nature and implications of making this directive.

_____ _____

(Signature of 2nd witness) **(Date)**

Name:

Identity document No.:

Home address / Contact address:

Home Tel. No. / Contact No.: