Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

ADVANCE HEALTH DIRECTIVE

This form is for people who want to make an Advance Health Directive in Western Australia.

Each section includes instructions on how to complete the form. For more information, read the *Advance Health Directive Guide*.

You must be 18 years or older and have legal decision-making capacity to make an Advance Health Directive.

(*See page xx of the Advance Health Directive Guide for more information*)

It is recommended that you speak with your medical doctor for advice before making an Advance Health Directive.

If you need help in understanding this form, please contact the National Accreditation Authority for Translators and Interpreters.

MY DETAILS

Use this section to record your personal details.

DATE: This Advance Health Directive is made under the Guardianship and Administration Act 1990 Part 9B on the _____ (*day*) of _____(*month*) 20 _____(*year*)

FIRST NAME: _____

MIDDLE NAME/S: _____

LAST NAME: _____

DATE OF BIRTH: _____(*day*)/_____(*month*)/_____(*year*)

RESIDENTIAL ADDRESS: _____

_____Postcode_____

POSTAL ADDRESS: _____

(if different to residential) _____Postcode_____

PHONE *(optional)*: _____

EMAIL *(optional)*: _____

ARE YOU OF ABORIGINAL OR TORRES STRAIT ISLANDER DESCENT?

□ Yes □ No □ Prefer not to say

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

MEDICAL AND / OR LEGAL ADVICE

Use this section to record the details of people who helped you make this Advance Health Directive.

You do not have to seek medical or legal advice to make an Advance Health Directive. However, it is recommended that you get advice from your medical doctor before making an Advance Health Directive.

You do not have to provide the name and contact details of people who have helped make your Advance Health Directive. However, it is helpful for health professionals and your family to know who helped make your Advance Health Directive in case they have questions about any sections in future.

Before making this Advance Health Directive:

□ I sought advice from a medical doctor □ I did NOT seek advice from a medical doctor

Name of doctor: _____ Practice: _____

Phone: _____

□ I sought advice from a lawyer □ I did NOT seek advice from a lawyer

Name of lawyer: _____ Practice: _____

Phone: _____

Did you discuss this Advance Health Directive with anyone else? For example, someone who is familiar with your decisions and may be able to answer any questions in the future.

□ Yes □ No

Name: _____ Relationship to you: _____

Phone: _____

MY HEALTH

THIS SECTION IS NOT LEGALLY BINDING

Use this section to record information about your current health that may affect your future healthcare.

This includes physical and mental health conditions. You may also wish to include information about past health or healthcare experiences that have impacted your preferences regarding healthcare.

It is strongly recommended that you talk to a health professional about how any current or previous illnesses or health conditions may affect your future health.

Put a line through any question you do not want to complete.

1) CURRENT HEALTH CONDITIONS

Do you have any current illnesses or health conditions? *(include physical or mental health conditions)*

2) FUTURE HEALTH CONDITIONS

Are you aware of possible future changes to your health that may occur as a result of your current illnesses or health conditions? *(include physical or mental health conditions)*

3) PAST HEALTH EXPERIENCES

Have you had any health or healthcare experiences (good or bad) that affect your preferences for future healthcare?

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

4) INFORMATION ABOUT YOUR HEALTH

In general, how much information do you like to know about your health? *Do you prefer to know lots of detail and all the possibilities? Or do you prefer to know only about the main issues and decisions?*

5) DAILY LIVING

How would you describe your current abilities in your day-to-day life?

Eating and drinking:

□ I can feed myself □ I sometimes need help □ I always need help

Going to the toilet (including managing an ostomy*)

□ I can go to the toilet by myself □ I sometimes need help □ I always need help

Bathing and showering:

□ I can bathe / shower myself □ I sometimes need help □ I always need help

Moving around (walking, using a wheelchair, moving into and out of a wheelchair):

□ I can move around by myself □ I sometimes need help □ I always need help

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

MY VALUES

THIS SECTION IS NOT LEGALLY BINDING

Use this section to write down the things that are important to you about your life and health.

In the future, if you are unable to make or communicate decisions about your health, this information will help your family and health professional(s) make decisions that reflect your values and preferences.

See page xx of the Advance Health Directive Guide for more examples.

Put a line through any question you do not want to complete.

1) WHAT MATTERS MOST?

What matters <u>most</u> to you in your life? What activities give you joy? What would you miss most if you could no longer do it? *Tick all options that apply to you. Include examples or more information if needed.*

□ Spending time with family and friends

□ Living independently

□ Being able to live or spend time on country

□ Being able to care for myself

□ Keeping active (e.g. playing sport, walking, swimming, gardening)

□ Hobbies and interests (e.g. music, travel, playing cards)

□ Religious and/or spiritual activities (e.g. prayer, attending religious services, meditation)

□ Cultural activities (e.g. ceremonies on country)

□ Working or volunteering

Use the space below to provide any other examples of what is important to you.

2) WHAT WORRIES YOU?

What worries you most when you think about your future health? *You can include physical issues such as pain, changes that will mean you might have to stop doing things that are important to you, or concern about people you love. See page xx of the Advance Health Directive Guide for more information and examples.*

3) QUALITY OF LIFE

What is important for your quality of life? *Everyone has a different view of what is important for a 'good' quality of life. Listed below are some statements about things that may be important to you. Tick the box that reflects how you feel about each statement.*

What the rankings mean

Important to me: I would not want to live without this ability (likely to influence treatment decisions)

I could live without it: I could adjust to living without this ability (may influence treatment decisions)

Not important to me: I would be OK living without this ability (would not influence treatment decisions)

Not sure: I'm not sure whether this is important for me or not

I can recognise my family and friends and spend time with them			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can communicate and be understood by others			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can breathe without a breathing machine			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can eat and drink independently			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can wash / dress with little or no help from others			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can control my bladder			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

I can control my bowels			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can move around with little or no help from others			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I am pain free for most of the time			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*
I can smell, taste and touch things			
☐	☐	☐	☐
Important to me	*I could learn to adjust if this was not possible*	*Not important to me*	*Not sure*

Use the space below to provide more details about what is important to you in terms of your quality of life.

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

4) CARE AT END OF LIFE

What is important for you at the end of your life? *It is helpful for your family and health professionals to know where you would prefer to receive end of life care and what is important for you at this time. It may not always be possible to choose where you receive care at the end of your life. Some aspects of care, such as pain relief, are easier to manage in a healthcare setting rather than at home.*

'End of life care' means the last 3 to 6 months of your life. Do not include your preferences for what happens after you die (e.g. your funeral).

Do you have a preference for where you receive end of life care?

□ **No** – *I would like to be wherever I can receive the best care for my needs at the time*

□ **Yes** – *where I die is important to me*

If Yes: *number the boxes below to show where you would prefer to receive care at end of life (1: first choice, 6: last choice)*

Location	**Preference *(1 to 6)***
At home	
Living with a loved one	
In hospital	
In a hospice / palliative care unit in hospital	
On country	
Other (please specify:	

Use the space below to provide more details about your preferences for end of life care.

Do you want to receive palliative care? *Palliative care is specialist care provided to people who have an advanced or progressive illness with little or no chance of cure. Palliative care identifies and treats symptoms, which may be physical, emotional, spiritual or social.*

□ **Yes** – *I would like palliative care* □ **No** – *I would not like palliative care*

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

What is important for you during your end of life care? *Think about the things that will be comforting for you at the end of life.*

Tick all that apply.

□ Having my pain managed and being comfortable. *Please provide details of what 'being comfortable' means to you.*

□ Having my loved ones around me. *Please provide details of people you would like with you and people you would not like to be present.*

□ Following important cultural or religious traditions (e.g. being able to visit country, dying on country). *Please provide details.*

□ Sound (e.g. quiet, music). *Please provide details.*

□ Other things (e.g. pets). *Please provide details.*

Would you like to be an organ / tissue donor?

□ Yes □ No

** Please note, that this section of the form only notes a pre-existing request to be an organ donor. Also note that if you refuse certain life-extending treatments, you may be ineligible to donate your organs or tissue. If you wish to be an organ donor, you need to complete an organ donation registration. Please visit xx for more information.*

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

MY HEALTHCARE DECISIONS

THIS SECTION IS LEGALLY BINDING

Use this section to record decisions about the types of healthcare you do and do not want to receive in future. This includes decisions about treatments that could extend the length of your life.

Life-extending treatments include feeding tubes, breathing machines and CPR. Some life-extending treatments can also help manage symptoms of an illness. This includes dialysis for kidney disease. For more information and examples of life-extending treatments please refer to pages xx in the Advance Health Directive Guide.

The decisions you record in this section will become legally binding. This means your doctor is required to follow these instructions if you are no longer able to make or communicate decisions about your healthcare.

It is strongly recommended that you talk to your medical doctor about this section so you can fully understand the decisions you record in this section.

Please draw a line though any sections you do not want to complete.

1) LIFE-EXTENDING TREATMENTS

What types of treatment would you like to receive if you have an advanced / incurable illness and it is likely that you will die within 12 months?

- □ I want all life-extending treatments
- □ I only want life-extending treatments if they will help manage my symptoms and keep me comfortable
- □ I only want pain relief and care to keep me comfortable (i.e. palliative care)

2) HEALTHCARE DECISIONS IF I AM SERIOUSLY ILL OR INJURED

Which treatments do you want to receive / NOT want to receive if you become seriously ill or injured in future?

Ticking 'I CONSENT' does not mean you will definitely have these treatments in future. You would only receive these treatments if needed. Health professionals can only offer treatments they think will help you.

For definitions of each of the treatments listed, please refer to pages xx of the Advance Health Directive Guide.

For some of these treatments, your decision may depend on the situation. For example, you may consent to CPR if it is likely that your preferences for quality of life would be maintained.

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

Treatment	*If treatment would help me in future*	
	I consent	**I do NOT consent**
CPR (cardiopulmonary resuscitation) *(external chest compressions to make the heart pump)*		
A permanent breathing tube inserted into my lungs *(intubation)*		
A permanent breathing tube inserted into my windpipe *(tracheostomy)*		
Being permanently fed through a drip *(intravenous feeding)*		
Being permanently fed through a tube into my stomach *(gastrostomy)*		
A permanent tube inserted into my kidneys to drain urine into a bag *(nephrostomy)*		
A permanent hole in my abdomen (stomach) with a bag attached to remove faeces *(colostomy)*		
A permanent tube inserted into my abdomen to clean my kidneys *(peritoneal dialysis)*		
Amputation of an arm or leg		
Receiving pain medication		
Receiving blood products such as a blood transfusion		
Prescribed antibiotics		

Would you like to take part in health and medical research if it is an option for you?

People can choose to take part in health and medical research. Researchers can only involve you in research if the research is in line with what you have agreed to in your Advance Health Directive.

	I consent	**I do NOT consent**
Taking part in health and medical research if it is consistent with my preferences in my Advance Health Directive.		

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

Other treatment decisions

Use this section to record details of other treatment decisions that you consent to receiving in certain situations. These decisions cover situations not already referred to in sections 1 & 2.

If there is not enough space here for all the treatment decisions you want to make, you can use the template at Appendix X in the Advance Health Directive Guide and attach the completed template to this Advance Health Directive form.

In the following circumstances:	
I CONSENT to:	**I DO NOT CONSENT to:**
In the following circumstances:	
I CONSENT to:	**I DO NOT CONSENT to:**
In the following circumstances:	
I CONSENT to:	**I DO NOT CONSENT to:**

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

SIGNATURE AND WITNESSING

You must sign this Advance Care Directive in the presence of an authorised witness and one other person.

If you are physically incapable of signing this Advance Health Directive, you can ask another person to sign for you. You must be present when the person signs for you and include a marksman/readover clause. Examples of such clauses can be found at Appendix X of the Advance Health Directive.

Signed by: *(signature of person making this Advance Health Directive)*

_____ **Date:** ___(*day*) / ___ (*month*)/ _____(*year*)

Witnessed by a person authorised to witness statutory declarations:

(authorised witness's signature): _____

(*authorised witness's full name*): _____

(*authorised witness's address*):_____

_____Postcode:_____

(*occupation of authorised witness*) _____

on (*date*): ____(*day*) /____ (*month*)/_____(*year*)

And by another person:

(*other witness's signature*): _____

(*other witness's full name*): _____

(*other witness's address*): _____

on (*date*): ____ (*day*)/____ (*month*)/_____(*year*)

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

OPTIONAL STATEMENT ABOUT ENDURING POWER OF GUARDIANSHIP

Use this section to record details of your Enduring Guardian(s) (if you have appointed someone).

If you do not have capacity to make or communicate treatment decisions and you require treatment, health professionals will first refer to your Advance Health Directive.

If your Advance Health Directive does not cover the healthcare decision needed, health professionals will seek a decision from the first person in your 'hierarchy of treatment decision-makers'. If you have appointed an **Enduring Guardian** with authority to make treatment decisions, this is the first person in the hierarchy. *For more information about the hierarchy see page XX of the Advance Health Directive Guide.*

Your Enduring Guardian/s cannot override the treatment decisions made in your Advance Health Directive unless circumstances have changed or could not have been foreseen by you when you made the Advance Health Directive.

Please tick the option which applies to you:

□ **I have not made an Enduring Power of Guardianship (EPG)**

OR

□ **I have made an Enduring Power of Guardianship (EPG)**

My EPG was signed on: ___(*day*) / ____ (*month*)/ _____(*year*)

A copy of my certified EPG is stored in the following location (be as specific as possible):

_____

_____

I appointed the following person/s as my Enduring Guardian/s.

Name: _____

Address: _____

_____Postcode:_____

Phone: _____ Email: _____

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

Name: _____

Address: _____

_____Postcode:_____

Phone: _____ Email: _____

I appointed the following person/s as my substitute Enduring Guardian/s.

Name: _____

Address: _____

_____Postcode:_____

Phone: _____ Email: _____

Name: _____

Address: _____

_____Postcode:_____

Phone: _____ Email: _____

Advance Health Directive of *(your full name)* _____

Date ____ / ____ / _____ *(your signature)* _____

(witness 1 signature) _____ *(witness 2 signature)* _____

INTERPRETER STATEMENT

Use this section if an interpreter helped you to write your Advance Health Directive.

If you used an interpreter to help you write your Advance Health Directive in English, your interpreter must complete this section.

Your interpreter should read the Information for Interpreters on page xx of the Advance Heath Directive Guide.

Your interpreter cannot witness your signature on the Advance Health Directive.

It is not essential that your interpreter is accredited with the National Accreditation Authority for Translators and Interpreters (NAATI).

Full name of interpreter: _____

Phone: _____ Email:_____

I am an accredited interpreter and translator with the NAATI:

□ YES □ NO

If yes, NAATI Number: _____

I am a family member or friend of the maker of this Advance Health Directive

□ YES □ NO

I confirm:

- when I interpreted this AHD form into _____language, the person appeared to understand the information in the document, AND
- the information recorded in this document was translated by me and accurately reproduces in English the original information and instructions of the person.

Signed: _____ Date: ___(*day*)/ ___ (*month*) / ___ (*year*)

(*Signature of interpreter*)