Attach person's label here

FT021550

Those who can speak on my behalf (substitute decision-maker/s):

Please give a copy of this completed document to all substitute decision-makers.

I have appointed an Enduring Guardian by completing the required Guardianship & Administration Board forms:

Enduring Guardian

Name: ______________________________

Telephone: ______________ (Home) ______________ (Work)

(Mobile) ______________ Date appointed: ______________

I have also appointed (name) ______________________________

as my ☐ joint or ☐ alternative Enduring Guardian

Telephone: ______________ (Home) ______________ (Mobile)

I have NOT appointed an Enduring Guardian as my substitute decision-maker, but would want the following person or people to speak for me (as my 'Person Responsible') if they are available, in order of preference.

1. Person Responsible

Name: ______________________________

Telephone: ______________ (Home) ______________ (Mobile)

______________ (Work) ______________

Relationship: ______________________________

2. Person Responsible

Name: ______________________________

Telephone: ______________ (Home) ______________ (Mobile)

______________ (Work) ______________

Relationship: ______________________________

I have given a copy of this ACD to:

GP ______________ Phone ______________

Solicitor ______________ Phone ______________

Enduring Power of Attorney ______________ Phone ______________

Other ______________________________

Facility:

Attach person's label here

FT021550

ADVANCE CARE DIRECTIVE FOR CARE AT THE END OF LIFE (TASMANIA)

This ADVANCE CARE DIRECTIVE (ACD) will be used to guide future medical decisions ONLY when you lose the ability to make or communicate your medical treatment decisions yourself. In this event, your PERSON RESPONSIBLE will make medical treatment decisions on your behalf, in consultation with the treating doctors responsible for your care at the time.

If a person lacks the capacity to understand and complete this form for themselves it may be completed by their legally appointed Enduring Guardian or by a "Person Responsible". Where possible the Person Responsible does so in the knowledge of the preferences or expressed wishes of the Person Concerned before they lost capacity.

Where "I/my" is shown in this document, it means the Person Concerned

THIS IS THE ADVANCE CARE DIRECTIVE FOR

Title ________ Surname ______________________________

Given names ______________________ Date of birth ______________

Address ______________________________

____

AND IS BEING COMPLETED BY ☐ self, or ☐ Person Responsible.

Please print your name and address below ______________________________

____

____

(Note: tick the 'self' box above if you are completing this ACD in your own writing or if another person is just writing down what you tell them. If you are writing on behalf of someone who lacks decision-making capacity, you should enter your own name next to 'Person Responsible', and attach any relevant documentation confirming your appointment as the Person Responsible.)

I request that my plans for my End of Life Care be followed by doctors.

PLANS FOR LIMITATION OF MEDICAL TREATMENT AT THE END OF MY LIFE

☐ I request that treatment aimed at prolonging life be withheld or stopped, and palliative care be provided (for symptom management, quality of life, comfort and dignity), if at some future time it is the opinion of the treating team responsible for my medical care that:

- significant recovery is highly unlikely, or
- the outcome of such treatment would be a permanent coma, or
- any other medical outcome that is unacceptable to me (detail here).

____

____

Attach person's label here

I request that my values, beliefs, and wishes for medical care generally be respected by my Person Responsible and doctors involved in my care.

MY VALUES AND BELIEFS

(please detail here the things that matter to you, which you think may be relevant when you can no longer speak for yourself, including any specific religious, spiritual or other practices to be observed)

PREFERENCES FOR TREATMENT TO MAINTAIN MY QUALITY OF LIFE

(detail here any outcomes that would be particularly unacceptable to you: e.g. *I fear being unable to speak and move myself, or, Being able to communicate with my family is very important to me so I would not want life-prolonging treatment if I was unable to talk to them, or, I do not want to be put on a breathing machine, or I do not want to be fed through a tube.* Please note: Palliative care may include antibiotics, operations, fracture repairs and other treatment intended only to maintain your quality of life.)

OTHER WISHES

Attach person's label here

If there is not enough room to print all your requests and wishes, please attach further pages as necessary. All additional pages need to be signed, dated and witnessed.

Are you a registered organ and tissue donor? ☐ Yes ☐ No

Are you a University of Tasmania body bequest donor? ☐ Yes ☐ No

Name of person completing this document ______________________

Signature ______________________ Date ______________

TRANSLATOR/INTERPRETER

I have provided a translation/interpretation in the ______________ language of the ACD form and any verbal or written information given to the Person Concerned/Person Responsible by others at the time of completion of this ACD.

Translator/interpreter signature ______________________ Date ______________

Translator/interpreter name, address and contact details (print) ______________________

WITNESS

It is assumed that a witness acts in good faith, is over 18, is unrelated to the PERSON CONCERNED, and must not be a known beneficiary in that person's will.

The witness must:

- Confirm the identity of the PERSON CONCERNED and/or PERSON RESPONSIBLE.
- Believe that the person understands that this document is about medical treatment decisions, and
- Be confident that the person is under no duress or pressure.

The witness can be a registered health care professional, but cannot be a paid personal carer.

Witness signature ______________________ Date ______________

Witness name, address and contact details (print) ______________________