



Revocation of advance care directive

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Part 1: Personal details

You must fill in your full name, date of birth and address. A phone number is optional.

Your full name:			
Date of birth: (dd/mm/yyyy)			
Address:			
Phone number:			

Part 2: Advance care directive details

I revoke my advance care directive.

Fill in the date you made the directive if known.

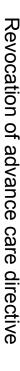




Revocation of advance care directive (cont.)

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Revocation by:					
(insert your full name)					
Part 3: Witnessin	9				
You must sign in	Signature of person revoking directive (you sign here)				
front of two adult witnesses at the same time.					
One witness must be	Each witness certifies that:				
a registered medical practitioner. Neither witness can be a person that you have appointed as your medical treatment decision maker.	 at the time of signing the document, the person revoking the advance care directive appeared to have decision-making capacity and understand the consequences of revoking the directive; and the person appeared to freely and voluntarily sign the document; and the person signed the document in my presence and in the 				
presence of the second witness; and					
	 I am not an appointed medical treatment decision maker of the person. 				
	Witness 1 – Registered medical practitioner				
A registered medical practitioner must	Full name of registered medical practitioner:				
complete this part of the form.	Qualification and AHPRA number of registered medical practitioner:				
	Qualification and Arm TA number of registered	medicai practitioner.			
	Signature of registered medical practitioner:	Date: (dd/mm/yyyy)			
	Witness 2 – Adult witness				
Another adult witness	Full name of adult witness:				
must complete this part of the form.					
	Signature of adult witness:	Date: (dd/mm/yyyy)			





Revocation of advance care directive (cont.)

Revocation by:

(insert your full name)

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f an interpreter is pre	sent when this do	cument is witnessed			
If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.	Name of interprete	er:			
	If accredited with the National Accreditation Authority				
	NAATI number:				
	I am competent to interpret from English into the following language:				
	I provided a true and correct interpretation to facilitate the witnessing				
	of the document.				
	Signature of interp	oreter:	Date: (dd/mm/yyyy)		

Part 4: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter	Name of interpreter:				
helped you to prepare this					
document, they complete this section. They can fill in this section before the document is witnessed or at the time the document is witnessed. Cross out Part 4 if not relevant.	If accredited with the National Accreditation Authority				
	NAATI number:				
	I am competent to interpret from English into the following language				
	When I interpreted into this language the person appeared to understand the language used in the document.				
	Signature of interp	•	Date: (dd/mm/yyyy)		

You have reached the end of this form.

It is recommended you take steps to inform your medical treatment decision maker(s) and any relevant health practitioner(s) that you have revoked your advance care directive.

It is recommended you take steps to retrieve any copies.