



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

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

Use this form if you need someone to sign an advance care directive for you at your direction.

Any advance care directive that you have previously made under this Act is automatically revoked (cancelled) when you complete this advance care directive.

This form is designed for adults to complete using the *Instructions for completing the advance care* directive form document.

Part 1: Personal details

i dit i i oroondi				
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:			
If you have no current health problems, cross out this section.	My current major health problems are:			
It is helpful to know if	Mark with an X if the statement below is relevant to you.			
you have completed an Advance	I have completed an Advance Statement under the			

Statement in relation to a mental illness.

Mental Health Act 2014 (Vic.).

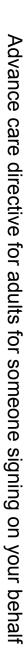




Advance care directive of:

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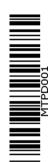
(insert your full name)		
	ent dec	e desiriation maker is legally required to first consider your values desired sions about your medical treatment.
values with them. You	can ap	atment decision maker is and discuss your preferences and point someone using the <i>Appointment of a medical treatment</i> Part 2 of the instructions for more information.
You may complete al	l, som	e, or none of the sections.
		hat matters most in my life: /hat does living well mean to you?)
In Part 2 you can write your values and preferences for your medical treatment. Refer to Part 2 a) of the instructions.		
	b) W	hat worries me most about my future:
Refer to Part 2 b) of the instructions.		
	tre (F	or me, unacceptable outcomes of medical eatment after illness or injury are: or example, loss of independence, high-level care not being able to recognise people or communicate)
Part 2 c) of the instructions includes a table with examples of health outcomes to help you complete this section.		





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Advance care directive (insert your full name)	of:		
Part 2: Values dire		e (cont.) ther things I would like known are:	
Refer to Part 2 d) of the instructions. Things you can include about your values and preferences are: • spiritual, religious, or cultural requirements • your preferred place of care • treatment with prescription pharmaceuticals (medicine) • treatment for mental illness • medical research			
procedures.	e) Ot	ther people I would like involved in discussions about my o	care:
Refer to Part 2 e) of the instructions.			
	,	I am nearing death the following things would be importante:	t
Refer to Part 2 f) of the instructions. Things to consider include: persons present, spiritual care, customs or cultural beliefs met, music or photos that are important.			
•	Selec	ct one statement below and mark your response with an X	
	and i	willing to be considered for organ and tissue donation, recognise that medical interventions may be necessary onation to take place.	
	l am dona	not willing to be considered for organ and tissue ition.	



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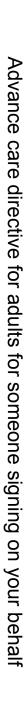
Advance care directive of:	
(insert your full name)	
Part 3: Instructional di	rective

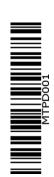
This instructional directive is legally binding and communicates your medical treatment decision(s) directly to your health practitioner(s). It is recommended that you consult a medical practitioner if you choose to complete this instructional directive.

- Your instructional directive will only be used if you do not have decision-making capacity to make a medical treatment decision.
- Your medical treatment decisions in this instructional directive take effect as if you had consented to, or refused to, begin or continue medical treatment.
- If any of your statements are unclear or uncertain in particular circumstances, it will become a values directive.
- In some limited circumstances set out in the Act, a health practitioner may not be required to comply with your instructional directive.

Cross out this page if you do not want to consent to or refuse future medical

reatment.	
Refer to Part 3 of the instructions for more information on how to complete your instructional directive. Keep in mind: you should include details about the circumstances in which you consent to or refuse treatment health practitioners can only offer treatment that is medically appropriate in an end-of-life care situation, certain medical interventions may be required for organ and tissue donation to take place.	a) I consent to the following medical treatment: (Specify the medical treatment and the circumstances) b) I refuse the following medical treatment: (Specify the medical treatment and the circumstances)





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Advance care directive of:
(insert your full name)

Someone signing at the direction of the person

Part 4: Expiry date (optional)

Only complete this part if you want this advance care directive to have an expiry date. Refer to Part 4 of the instructions.

Part 5: Witnessing

If you need someone to sign for you, at your direction, they must be 18 years or older. They cannot be one of the witnesses or your appointed medical treatment decision maker.

They sign and date

They sign and date the form at your direction and in front of you and the two witnesses.

sign this advance care directive sign this advance care directive at the direction and in the presence of the person giving the directive and in the presence of two witnesses.			
Full name of the person making the advance ca	are directive:		
Full name of person signing at their direction:			
Signature of person signing at their direction:	Date: (dd/mm/yyyy)		



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Advance care directive of:	
(insert your full name)	
 at the case appoints of the case appoints the case appoints the case appoints and the case appoints a	the time of signing the document, the person giving is advance care directive appeared to have decision-making spacity in relation to each statement in the directive and speared to understand the nature and effect of each statement the directive; and e person appeared to freely and voluntarily direct another erson to sign the document; and e person signed the document in the presence of the person recting them to sign and in my presence and in the presence the second witness; and am not an appointed medical treatment decision maker the person.
Witn	ess 1 – Registered medical practitioner

A registered medical practitioner must complete this part of the form.

Another adult witness must complete this part of the form.

•			
Full name of registered medical practitioner:			
Qualification and AHPRA number of registered	medical practitioner:		
Signature of registered medical practitioner:	Date: (dd/mm/yyyy)		
Witness 2 – Adult witness			
Full name of adult witness:			
Signature of adult witness:	Date: (dd/mm/yyyy)		



Advance care directive of:

after the document

is witnessed.

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(insert your full name)		
If an interpreter is pre	esent when this document is witnessed	
If an interpreter is present at the time the document is witnessed, they	Name of interpreter:	
	If accredited with the National Accreditation Authority	
complete this section immediately	NAATI number:	

I provided a true and correct interpretation to facilitate the witnessing of the document.

I am competent to interpret from English into the following language:

Signature of interpreter: Date: (dd/mm/yyyy)

Part 6: Interpreter statement

If an interpreter assisted in the preparation of this document

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.

Refer to Part 6 of the instructions.

If an interpreter

Name of interpreter:			
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 interpreter:		Date: (dd/mm/yyyy)	

You have reached the end of this form.

It is recommended that you **review your advance care directive every two years**, or whenever there is a change in your personal or medical situation.

- Please keep your original advance care directive safe and accessible for when it is needed.
- Ensure that your medical treatment decision maker (if any) has read and understood its contents.
- Your advance care directive can be uploaded on MyHealth Record and should be shared with your medical treatment decision maker and relevant health practitioner(s) / health service(s).