MTPD004

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.

Date of directive: (dd/mm/yyyy)	

Revocation of advance care directive

VICTORIA State Government

MTPD004

Revocation of advance care directive (cont.)

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

Revocation by: (insert your full name)	

Part 3: Witnessing

You must sign in front of two adult witnesses at the same time.

One witness must be a registered medical practitioner.

Neither witness can be a person that you have appointed as your medical treatment decision maker.

Signature of person revoking directive (you sign here)

Each witness certifies that:

- 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 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

Another adult witness must complete this part of the form.

Full name of adult witness:

Signature of adult witness: Date: (dd/mm/yyyy)

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Revocation of advance care directive (cont.)

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Revocation by: (insert your full name)	

If an interpreter is present when this document 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 interpreter:

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 interpreter:	Date: (dd/mm/yyyy)

Part 4: Interpreter statement

If an interpreter assisted in the preparation of this document

If an 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.

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 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.